



Ministry of Finance

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National Situation
Analysis of
Children and Women
in Ethiopia





National Situation Analysis of Children and Women in Ethiopia

FOREWORD

The Federal Democratic Republic of Ethiopia is on the cusp of transformational changes that could solidify its place as a leader on the African continent and an important actor in the global landscape. As the second most-populous country in Africa, and a country that has demonstrated resilience in the face of recurrent hazards, Ethiopia can be a country model for inclusive development that is sustainable, equity-focused and risk-informed.

In pursuit of the Sustainable Development Goals of the United Nations Agenda 2030, the African Union's Agenda 2063 and Ethiopia's own current national development agenda, the Second Five-Year Growth and Transformation Plan 2015/2016-2019/2020 (GTP II), there must be broad-scale commitment across country stakeholders to leave no one behind.

This report examines the situation through the lens of the well-being of children, adolescents and women. Ethiopia has scored noteworthy achievements, for example in monetary poverty reduction and in some aspects of health, nutrition and education. However, success is not yet occurring at a fast enough pace and large enough scale to achieve national and global goals. The policy and legal landscape sets the stage for responding to all elements of the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). However, full implementation and enforcement of national policies and legislation is essential to effect meaningful improvements for women, children and all members of Ethiopian society.

Estimates of pervasive multi-dimensional child poverty, with almost 9 out of every 10 children experiencing multiple deprivations (in dimensions such as health, nutrition, education, protection, housing, water and sanitation) serve as a call for coordinated multi-sectoral, multi-stakeholder solutions. The disparities noted in the report have their roots in gender inequality, social exclusion, monetary poverty and poor coping capacity to withstand and rebound from shocks. Tackling those root factors in earnest can convert them from drivers of inequities and shortfalls to levers of transformative change for all.



EXECUTIVE SUMMARY

With aspirations to become a low-middle-income country by 2025, Ethiopia has made some strides with respect to the Sustainable Development Goals (SDGs). However, Ethiopia's rank of 173rd out of 189 countries on the Human Development Index indicates that, while the country is on the path, it has a way to go to reach its destination in terms of inclusive, sustainable development for all. This report examines the current national context and Ethiopia's progress in safeguarding the rights and improving the welfare of children, adolescents and women in different realms. It also identifies causes of key shortfalls and inequities to directly focus on issues that need to be addressed through risk-informed, equity-focused efforts. Findings and insights presented in the report are based on nationally endorsed data sources, such as the Ethiopia Demographic and Health Survey (EDHS), Ethiopia Mini Demographic and Health Survey (EMDHS), Household Consumption and Expenditure Survey, budget analyses, published scientific literature, and sector-specific analyses and administrative data (e.g., the Health Management Information System and Education Management Information System). The body of the report includes specific data sources for all cited data.

THE NATIONAL CONTEXT

There has been tremendous progress in monetary poverty reduction (from 45.5 per cent in 1995/1996 to 23.5 per cent in 2015/2016). However, children in present-day Ethiopia bear a greater poverty burden than adults: 32.4 percent of children under 18 compared with 29.6 per cent of adults are monetarily poor in 2011. Additionally, 88 per cent of children live in multi-dimensional poverty, experiencing deprivations in domains such as health, nutrition, housing, education and/or water, sanitation and hygiene (WASH). Poverty in women is multi-faceted and linked to a lack of women's economic, social and political empowerment, including their access to and control over information, services, resources and commodities.



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At a macro level, Ethiopia's economic growth has outperformed many countries in recent years. Between 1999/2000 and 2016/2017, the country's Gross Domestic Product (GDP) per capita increased from US\$ 129 to US\$ 863. However, the rate of economic growth has slowed slightly in recent years (10.2 per cent in 2017, projected at 9.7 per cent for 2019 and 9.9 per cent for 2020). This and other economic realities (e.g., double-digit inflation, low public saving rates, rising debt levels) can have major implications in terms of public finance for children. Public spending issues already exist with respect to: (1) the overall amount of resources made available for child- and adolescent-sensitive service delivery, (2) how available resources are allocated, and (3) how necessary resources are mobilized through a diversified funding base. A 2018 UNICEF-supported SDG financing analysis estimated that achieving child-sensitive SDGs would require approximately US\$ 230 per capita, per year—far higher than the estimated investment of US\$ 40 per capita in 2018.

Demographic changes occurring within the country have a direct bearing on women and children. With the country's rapid population growth rate (currently 2.85 per cent), Ethiopia's estimated 2019 population of 98,665,000 will double in size by 2050. This growth is largely spurred by high fertility in rural areas and among the poorest women (each, on average, having more than five children). Urbanization is another demographic phenomenon that will shape the country's development path. The current urbanization rate of 21 per cent is projected to increase to 31 per cent by 2037, driven largely by rural-urban migration. Out-of-school adolescent girls constitute one of the largest groups of internal migrants, and they are highly vulnerable to adverse outcomes, such as poor livelihoods, exploitation and abuse.

KEY ACHIEVEMENTS, SHORTFALLS, INEQUITIES AND THEIR CAUSES

KEY ACHIEVEMENTS

- Pro-poor social protection programmes introduced and/or replicated across the country
- Reduction in monetary poverty
- New/revised policy frameworks (Charities and Societies Act, 2019) that can foster an enabling environment for non-State actors to contribute to child and adolescent well-being
- Unprecedented gains in child survival and reductions in child malnutrition rates (particularly for stunting)
- Physical infrastructure improvement (roads, schools, health facilities) to support the provision of child- and adolescent-sensitive services in social sectors
- Introduction of quality improvement strategies in some sectors (e.g., health, education)
- New institutional arrangements to address shortfalls (e.g., related to birth registration)

KEY SHORTFALLS AND INEQUITIES

- Pervasive multi-dimensional child poverty, reflecting deprivations in several domains (health, nutrition, education, WASH, child protection)
- National shortfalls in outcomes at age extremes (early childhood, adolescence)
- Higher mortality among boys than girls
- Persistent vulnerability of adolescent females
- Persistent regional disparities in key indicators

ILLUSTRATIVE CAUSES OF KEY SHORTFALLS AND INEQUITIES

- Immediate:
 - › Below-target coverage of high-impact interventions/ services
- Underlying:
 - › Recurrent hazards (climate, economic, socio-political)
 - › Limited 'whole system' coordination (federal and regional), particularly for crosscutting issues such as child protection
 - › Insufficient adaptations of programmes/programme approaches in lowland versus highland areas
 - › Persistent quality gaps despite quality improvement strategies
 - › Incomplete policy implementation/enforcement
 - › Multi-dimensional poverty
- Structural:
 - › Slow pace of economic diversification
 - › Sub-optimal levels/sources of public finance for children
 - › Persistent social and cultural beliefs and norms that compromise child welfare
 - › Outstanding policy gaps (justice for children, violence against children in domestic settings)

Recurrent hazards also shape the national context. Ethiopia experiences cyclical hazards that push the bounds of both household and system resilience. In 2019, an estimated 8.86 million people are in need of humanitarian assistance. Children have been bearing a disproportionate humanitarian burden, accounting for 29 per cent of displaced males and 30 per cent of displaced females. Tigray, Afar, Benishangul-Gumuz, Gambella and Somali host the majority of Ethiopia's estimated 655,105 documented refugees, of which 64 per cent are under age 18. In addition to contending with humanitarian conditions, affected children, adolescents and women face an array of challenges related to health, food security, access to safe water and protection against violence and exploitation.

How Ethiopia fares vis-à-vis gender equality is central to protecting its women and children and promoting inclusive development. The 1995 Constitution of the Federal Democratic Republic of Ethiopia is the umbrella law that articulates the rights conferred on all Ethiopians, regardless of gender. There are additional legal frameworks, such as the Women's Policy and Strategy and the Women's Development Package (2016), but operational challenges limit their full implementation.

There are other equally important aspects of equity and inclusion. Four regions—Afar, Benishangul-Gumuz, Gambella and Somali—have a long-standing history of lagging behind the rest of the country

on a multitude of development indicators. Some sectors (e.g., education and health) have special strategic priorities or have made special provisions to support the needs of children and women in those regions. There is growing momentum and political will for tailored strategies and approaches to address vulnerabilities and build resilience in those regions, particularly in lowland areas, Ethiopia's poorest agro-ecological zone. Deliberate efforts are required to ensure that pastoralists, who are largely concentrated in Somali, Afar, Oromia and Southern Nations, Nationalities and Peoples (SNNP), are not left behind.

With regard to equity and inclusion, persons with disabilities are an historically underserved subgroup. Best-available data show that approximately 7.8 million people live with some form of disability in Ethiopia. The magnitude of child disability in Ethiopia is difficult to estimate due to the absence of surveys and accurate tools on various aspects of child functioning. Nonetheless, it is estimated that children and youth under the age of 25 constitute approximately 30 per cent of all people with a disability in Ethiopia. Children with disabilities bear a disproportionate burden in terms of adverse outcomes, and have the highest rate of extreme poverty (27 per cent), according to the 2015/2016 Household Consumption and Expenditure Survey. Ethiopia's legal and policy landscape vis-à-vis disability has evolved (e.g., National Action Plan for Persons with Disabilities 2012-2021, Federal Ministry of Education (FMoE) Master Plan for Special Needs and Inclusive Education 2016). However, existing legal frameworks still centre on a clinical or medical model approach. There is scope for further attention on human rights or social issues related to disability.

THE STATE OF ETHIOPIA'S CHILDREN AND WOMEN—

The Convention on the Rights of the Child (CRC) is a globally endorsed framework that mandates all countries to address the multiple aspects of child welfare and development. There is also a Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), a treaty that serves as an international bill of rights for women. Ethiopia is a signatory to both. Since 2015, there has been an expansion of Ethiopia's policy and legal landscape to safeguard the rights of both women and children. Although there have been achievements, critical gaps remain, as described below.



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EARLY CHILDHOOD DEVELOPMENT (ECD)

In 2010, Ethiopia approved a national, multi-sectoral Early Childhood Care and Education (ECCE) Policy Framework, as well as an ECCE Strategic Operational Plan and Guidelines, with a memorandum of understanding signed between the Federal Ministries of Education, Health and Women's and Children's Affairs. Those sectors are currently updating the policy framework to address identified gaps and ensure alignment with global ECD standards, such as UNICEF's Nurturing Care Framework. Policy gaps exist in relation to responsive caregiving and security and safety dimensions of ECD. There is no cross-sectoral entity or platform at federal or regional levels to: (1) provide oversight for the roll out and replication/scale up of high-impact sectoral interventions related to ECD; or (2) coordinate planning, implementation or monitoring of ECD interventions across sectors and stakeholders. It is also difficult to track financing or expenditures related to ECD.

Data on all elements of the ECD Index (percentage of children aged 36–59 months who are developmentally on track in literacy-numeracy, physical, social-emotional, and learning domains) are not available to track ECD status and progress. There is also a lack of child protection data on very young children, and limited data on caregiving practices among parents and caregivers.

EDUCATION

According to the FMoE, 26.8 million children are enrolled across approximately 40,000 primary and secondary schools in the country. Enrolment has increased at all levels of schooling, and the gender divide is narrowing. Multiple regions have primary school enrolment ratios above 100 per cent; however, there is a large over-age school population.

Despite improvements in school enrolment, there is a low transition rate from primary to secondary for both boys and girls, a by-product of factors such as high dropout rates across the primary cycle (less than 6 out of 10 learners complete primary education), and supply-side factors such as the much smaller number of secondary schools relative to primary schools in the country (ratio of 1:10), despite Ethiopia's young population and the significance of adolescents in national security, growth and development. There are persistent challenges that contribute to low student learning outcomes and the sub-optimal development of foundational and transferable skills that equip children to be productive members of society.

HEALTH

Ethiopia has made notable strides in overall child survival, with a reduction in the under-five mortality rate, from 123 per 1,000 live births in 2005 to 55 per 1,000 live births in 2019. Similar declines have occurred in the infant mortality rate, from 77 per 1,000 in 2005 to 43 per 1,000 in 2019. Both infant and under-five mortality have declined since 2016, but there has been no improvement in neonatal survival in recent years. This, coupled with the fact that maternal mortality is still high (412 per 100,000 according to the 2016 EDHS), suggests that there is an unfinished agenda with respect to maximizing the coverage and quality of high-impact maternal and neonatal health interventions, particularly during the postnatal period.

The coverage of several high-impact interventions has increased since 2016, but national shortfalls persist, as do disparities according to region, urban-rural residence, household socioeconomic status and women's level of education. Some disparities are narrowing, for example between 2016 and 2019 the rate of skilled delivery in Somali and Oromia—two regions with historically low rates of skilled delivery—increased from 16.4 per cent to 30.6 per cent, and from 19.7 per cent to 43.7 per cent, respectively. However, for some interventions there has been a stagnation or deterioration of coverage in urban areas (where rates have historically been high). For example, the urban coverage rate for at least one antenatal care visit in 2019 (84.5 per cent) is lower than it was in 2016 (90.1 per cent).

In addition to increasing the coverage of various high-impact interventions and services, quality transformation in healthcare has been a priority under the current Health Sector Transformation Plan (HSTP), with several quality initiatives and processes in the health sector. However, a 2016 Service Availability and Readiness Assessment highlighted major shortcomings with respect to basic health facility readiness. For example, only 30 per cent of health facilities had improved water sources, with a huge disparity between urban and rural health facilities (76 per cent and 20 per cent, respectively). There are also shortcomings related to core pillars of the health system, such as the health workforce, and drug and pharmaceutical management.

NUTRITION

The national prevalence of chronic malnutrition (stunting) in children under 5 years old was 58 per cent in 2000, 38 per cent in 2016 and currently stands at 37 per cent in 2019. Rates for child wasting (a measure of acute malnutrition) were 12 per cent in 2000, 10 per cent in 2016 and currently stand at 7 per cent in 2019. The country's under-nutrition rates remain higher than the average rates estimated for Africa as a whole, and due to Ethiopia's population size, the country accounts for a large malnutrition burden on the continent.

According to the 2019 EMDHS, under-five stunting rates are highest for 24- to 35-month-old children (45.1 per cent), children in the two lowest wealth quintiles (each 41.9 per cent), children

whose mothers have no formal education (41.7 per cent), rural children (40.6 per cent) and boys (40.2 per cent). Similar patterns are also observed for wasting, and there are large disparities by region. With a national prevalence of 0.6 per cent, overweight/obesity is not a major form of child malnutrition in Ethiopia, although children in Addis Ababa have the highest rate (2.5 per cent).

Women's nutritional status is a crucial component of Ethiopia's efforts to end malnutrition in all its forms. Roughly one out of every four women aged 15-49 years in Ethiopia is thin (body mass index (BMI) <18.5 kg/m²), while 7.6 per cent are overweight or obese (BMI ≥25). Micronutrient deficiencies are a public health concern: 2016 data shows that anaemia affected almost one out of every four women of reproductive age. Anaemia takes an even greater toll on children, affecting 56.9 per cent of children aged 6-59 months (67.8 per cent of children in the lowest wealth quintile) in 2016. The low 2019 coverage of Vitamin A supplementation among children aged 6-59 months (47.1 per cent), which is not vastly different from the rate documented in 2016 (44.7 per cent), suggests that anaemia might not be the only micronutrient deficiency of concern among children.

Available evidence suggests that nutrition improvement in women and children is a complex inter-play of behaviours (e.g., infant and young child feeding practices), food systems, and a host of other factors such as poverty, WASH and mitigating the impacts of hazards. There is also extensive gender inequality in both food and micronutrient deprivation in all age groups. Important contributors to nutritional status, such as infant and young child feeding practices, vary considerably by region and wealth quintile.

There is a national shortfall on key indicators, such as the exclusive breastfeeding rate, which is only 58.8 per cent in 2019. The issue of minimum acceptable dietary standards affects all children, regardless of socioeconomic status, area of residence, level of maternal education or other factors.



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CHILD PROTECTION

Child protection has many dimensions, such as violence, exploitation and abuse; harmful practices, such as child marriage and female genital mutilation (FGM); child labour; justice for children; and birth registration within civil registration and vital statistics systems. Children on the move may be at greater risk of various forms of violence and exploitation (including trafficking) than other populations of children, all of which require redoubled focus.

There has been notable progress in reducing child marriage, with 40 per cent of females aged 20-24 years married by age 18, and 14 per cent married by age 15. Despite this progress, the median age at first marriage is still below the legally permitted age of marriage (18 years). Compared to progress over the past 10 years, progress will need to be six times faster if child marriage is to be eliminated by 2030. Like child marriage, FGM rates have declined, however the national average is still high (65 per cent in the 15-49 year age group). FGM remains almost universal among women of reproductive age in Afar and Somali. Although reported FGM rates are far lower among girls aged 0-14 years (15.7 per cent) than among all women of reproductive age, in order to eliminate FGM by 2030, progress will need to be seven times faster than the progress observed over the past 10 years.

Other aspects of child protection affect large numbers of children. For example, a 2015 National Labour Survey found that 24.2 per cent of children aged 5-17 years (29.1 and 18.9 per cent of male

and female children, respectively) were engaged in child labour. Rural adolescent males are most likely to be involved in child labour.

According to the 2016 EDHS, more than one out of every four females aged 15-49 years (26 per cent) reported ever experiencing physical or sexual violence. Data from the multi-country Young Lives longitudinal study, of which Ethiopia is a part, shows that violence against children, largely in the form of physical punishment and emotional abuse, is prevalent and normalized. The magnitude, drivers and impacts of various forms of violence against boys are not fully understood due to limited evidence.

Although survey data on specific issues (birth registration, FGM, child marriage, child labour) are available, there are gaps in routine or administrative data on all dimensions of child protection. Despite the existence of various policy and legal frameworks, there are still policy gaps that impede action (e.g., the age of criminal responsibility and violence in domestic settings). Enforcement of existing legislation at the sub-national level is also a bottleneck. Addressing child protection in its totality must involve addressing underlying factors such as demand for services, as well as structural factors such as investment in critical system inputs (e.g., a trained social service workforce for child protection, case management, information systems) and addressing harmful gender and social norms and beliefs.

ADOLESCENTS

Development efforts to date have largely focused on adolescent girls through ending child marriage, formal primary education, menstrual hygiene management, sexual and reproductive health and some aspects of nutrition. Other aspects of development (mental health, skills for employability, civic and economic participation, programming with and for adolescents in humanitarian settings) warrant further attention. A recent analysis of gender equality found that a significantly larger proportion of adolescent males are undernourished than adolescent females (59 per cent and 28 per cent, respectively). This finding is just one illustration of the need for adolescent boys and girls to be targeted by age-appropriate, gender-sensitive interventions.

Data suggest that various phenomena affecting adolescents are interrelated. For example, females who get married in childhood are less likely to be employed than females who are/were not child brides, and when they are employed, they are more likely to be engaged in unskilled occupations. There is also limited but compelling evidence that girls who drop out of school are likely to get married as girls, and/or become teen mothers. Out-of-school girls are a highly vulnerable sub-population on the move.

Cultivating opportunities for adolescent empowerment and participation is central to reaping a demographic dividend. However, there remain social and cultural drivers and deterrents (e.g., related to girls' education, child marriage, boys as wage earners). Adolescent participation requires multiple forums and entry points to give adolescents the social and political space to be heard in the public domain. Although conservative gender- and age-related social norms persist as possible factors that limit adolescent voice and agency within families and communities, Ethiopia's current state of political transformation is cultivating opportunities for greater adolescent agency.

WATER, SANITATION AND HYGIENE

In the Millennium Development Goal era, there was a global focus on access to improved drinking water sources and improved sanitation. Ethiopia and other countries are now being held to a higher standard: safely managed water and sanitation. Based on the 2019 Joint Monitoring Programme (JMP) report, only 11 per cent of Ethiopia's population is using safely managed drinking water, a minimal increase since 2010, when the estimate was 8 per cent. The rural-urban divide is vast: 5 per cent and 38 per cent, respectively. Considering WASH deprivations that contribute to multi-dimensional child poverty, there have been significant improvements in access to safe drinking

water since 2011. However, the percentage of children deprived of safe drinking water is still high (according to analyses using 2016 EDHS data: 59 per cent of children under 5 years; 56 per cent of 5- to 17-year-olds). Children living in rural areas are much more deprived of safe drinking water than their urban counterparts (63 per cent and 14 per cent, respectively).

In addition to water, other dimensions of WASH require focus. Rural populations and the poorest households are the most disadvantaged in terms of sanitation, and deprivation in sanitation is one of the largest contributors to multi-dimensional child deprivation in Ethiopia. Among all children, the rate of deprivation of this basic right is 89 per cent, with children in rural areas being much more deprived than children in urban areas (94 per cent and 53 per cent, respectively). Hygiene remains a major gap in emergency and non-emergency settings.

SOCIAL PROTECTION

Based on 2015/2016 data, one out of every four residents of Ethiopia can be classified as absolute poor. The government has made strides in leveraging both domestic and external resources for pro-poor programmes, and there have been milestone policies and plans (e.g., National Social Protection Policy (2014), National Social Protection Strategy (2016) and Social Protection Action Plans at federal and regional levels). The social protection programme landscape is evolving, with the emergence of a multi-stakeholder National Social Protection Platform and various social protection programmes. The country's flagship social assistance programme, the Productive Safety Net Programme (PSNP), currently covers 8 million households. The Urban Productive Safety Net Project (UPSNP) was launched in 2016 and currently covers 11 cities and more than 600,000 households. In 2019, an urban destitute component was introduced, which has the potential to extend social assistance to particularly hard-to-reach and at-risk urban populations, such as children living and/or working on the streets. The Community-Based Health Insurance (CBHI) scheme is being rolled out across the country. It provides health financing measures to the informal sector. The government and many donors are aiming to effectively link the PSNP, UPSNP and the CBHI to provide integrated social protection measures to the most vulnerable individuals, based on the five key pillars of the National Social Protection Policy. The PSNP embraces a shock-responsive element through a federal contingency budget, which can serve the transitory needs of PSNP and humanitarian relief clients. As part of the integrated systems agenda in social protection, there is a vision to link humanitarian relief measures with long-term development measures.

CROSSCUTTING RECOMMENDATIONS

Based on the evidence considered for the Situation Analysis, the following are crosscutting recommendations. (1) In the next five years, invest in streamlined / rationalized management, coordination and mutual accountability mechanisms that are evidence-informed and create a space for children, including adolescents, in the sub-national implementation of national (GTP) and global (SDG) goals. (2) Leveraging the new Charities and Societies Act, and through a formal collaboration between State and non-State actors (civil society organizations, private-sector entities, development partners), formalize mechanisms for routine and meaningful participation of children, including adolescents, using innovative modalities for their engagement (social media and digital platforms). (3) To better position the country to reap the demographic dividend, pursue formal agreements and/or institutional arrangements (between FMoE and private-sector entities and/or civil society organizations) to



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build marketable skills in different sub-sets of children (in- and out-of-school adolescents, urban poor adolescents, adolescents in humanitarian settings). (4) Over the next two years, design and implement integrated humanitarian and development / resilience-building programmes that align development approaches with humanitarian needs emerging from displacement, migration and/or other phenomena resulting from shocks. This model would engage partners and leverage interventions from different sectors to address root causes of vulnerability to shocks and migratory pressures for 'children on the move' in regions such as Somali, Oromia, Amhara and SNNP—where vulnerability and humanitarian need, as well as the potential for national impact (particularly for the latter three regions, which account for 80 per cent of Ethiopia's population) is greatest. (5) Improve resource mobilization, budget allocation, budget use and expenditure tracking through the lens of public finance for children, including a shift from off-budget to on-budget support, and instituting measures that facilitate transparent tracking in relation to emerging priorities, such as ECD and adolescent development and participation. (6) Adopt a 'whole system' approach to enhance protective factors that reduce vulnerabilities in out-of-school girls and boys to adverse outcomes and circumstances (trafficking, child marriage, commercial sexual exploitation of children, teenage pregnancy, multi-dimensional poverty that is intergenerational). This whole system approach should entail addressing deep-seated social beliefs and norms that underpin different vulnerabilities in females compared to males, as well as coordination and joint programming between sectors or programme areas (e.g., child protection, health, education, social protection). (7) Establish costed operational plans for gender mainstreaming in sectors/line ministries (gender balance and gender-sensitivity in workforce development and management, including frontline service providers; expansion and maintenance of gender-sensitive infrastructure; violence prevention and response mechanisms, etc.). The Ministry of Women, Children and Youth (MoWCY) should be equipped with the mandate, resources and capacity to foster joint action across line ministries and with non-State actors. (8) In light of rapid urbanization, roll out integrated urban programming in small- and medium-sized towns, not just in large urban centres such as Addis Ababa and Dire Dawa. This programming should address the holistic prevention and response needs of children, adolescents and households in urban/peri-urban settings. (9) Strengthen the availability and quality of administrative data on children, including adolescents, by (a) developing legal and policy frameworks, and (b) formalizing institutional arrangements for harmonized data production, data sharing, interoperability and data access within and across sectors. (10) Implement a child- and adolescent-focused research agenda that addresses priority research questions.

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ACRONYMS

ANC	Antenatal Care
ARV	Antiretroviral
AARR	Average Annual Rate of Reduction
B-G	Benishangul-Gumuz
BMI	Body Mass Index
CBHI	Community-based Health Insurance
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CLTSH	Community-led Total Sanitation and Hygiene
CRC	Convention on the Rights of the Child
CSA	Central Statistical Agency
CSO	Civil Society Organization
DFID	Department for International Development (United Kingdom)
DPT	Diphtheria, Pertussis and Tetanus
EC	Ethiopian Calendar
ECCE	Early Childhood Care and Education
ECD	Early Childhood Development
ECDI	Early Childhood Development Index
ECE	Early Childhood Education
EDHS	Ethiopia Demographic and Health Survey
EFY	Ethiopian Fiscal Year
EMDHS	Ethiopia Mini Demographic and Health Survey
ESDP	Education Sector Development Programme
ETB	Ethiopian Birr
FGM	Female Genital Mutilation
FMoE	Federal Ministry of Education
FMoH	Federal Ministry of Health
GDP	Gross Domestic Product
GTP	Growth and Transformation Plan
HSTP	Health Sector Transformation Plan
IDP	Internally Displaced Person
IGME	Inter-agency Group for Child Mortality Estimation
IN-SCT	Integrated Basic Social Services with Social Cash Transfer
JMP	Joint Monitoring Programme
MCD	Multi-dimensional Child Deprivation
MICS	Multiple Indicator Cluster Survey
MoLSA	Ministry of Labour and Social Affairs
MODA	Multiple Overlapping Deprivation Analysis

MoWCY	Ministry of Women, Children and Youth
NGO	Non-governmental Organization
NNP	National Nutrition Programme
NSPP PMTCT	National Social Protection Policy Prevention of Mother-to-Child Transmission
PSNP	Productive Safety Net Programme
RMNCH	Reproductive, Maternal, Newborn and Child Health
SD	Standard Deviation
SDG	Sustainable Development Goal
SNNP	Southern Nations, Nationalities, and Peoples
UN	United Nations
UNICEF	United Nations Children's Fund
UPSNP	Urban Productive Safety Net Programme
WASH	Water, Sanitation and Hygiene

Introduction

With an estimated total population of 98,665,000 in 2019, Ethiopia is the second most-populous country in Africa.^{1,2} As a leader in the Horn of Africa, present-day Ethiopia embodies tremendous potential and hope, balanced against notable risks and hazards that must be considered as the country aspires to achieve broad-scale growth and transformation.

Women, children and adolescents in Ethiopia are living in a dynamic context where there have been strides in some development indicators. However, benefits do not yet extend to all individuals and groups within the country's borders. There are also development issues for which achievements are lagging. Now is an opportune time to take stock of achievements, critical success factors, bottlenecks and barriers. This report rigorously examines the current national context and Ethiopia's progress in safeguarding the rights and improving the welfare of its children, adolescents and women in different realms. It also identifies drivers and determinants of key shortfalls and inequities, with the aim of supporting risk-informed, equity-focused efforts to achieve sustainable development for all.

HOW THIS REPORT IS ORGANIZED—This report is divided into two main sections. The first section examines different aspects of the national context—from progress on Sustainable Development Goals (SDGs), to the economic situation, and other crosscutting national issues that can significantly impact children, adolescents and women (e.g., population dynamics, hazards, equality and inclusion). The second section of the report provides an in-depth examination of the status of women, children and adolescents, starting first with a general overview of progress related to the Convention on the Rights of the Child (CRC) and Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), then delving into specific programme or sector-specific issues (Early Childhood Development (ECD); Education; Health; Nutrition; Water, Sanitation and Hygiene (WASH); Adolescents; Child Protection; Social Protection). Each of these programme/sector-specific chapters describes the policy and stakeholder landscapes and the status of key indicators related to that area. There is also an examination of different causes of specific shortfalls and inequities, followed by a concise set of sector-specific recommendations. Annex 1 highlights regional and other disparities in key indicators by sector/programme area. Crosscutting recommendations appear at the end of the report.

ABOUT THE DATA PRESENTED IN THIS REPORT—An important caveat related to the data presented in this report relates to the fact that some of the indicator data are point estimates derived from a cross-sectional household survey, such as the Ethiopia Demographic and Health Survey (EDHS). There is a degree of imprecision associated with survey estimates, whereby the true value of an indicator actually lies within a range of possible values. This is particularly salient for some domains (e.g., nutrition) that might not have informed the sample-size calculations used for a particular survey. As such, some differentials, for example when examining regional variations in key indicators, should be interpreted as best-available estimates. To the extent feasible, the sector-specific chapters of this report entail triangulation of different sources of evidence to further aid in 'unpacking' true patterns and differentials that exist in relation to various outcomes in women, children and adolescents.

1 Central Statistical Agency. 2013. Population Projections 2007-2037. (Central Statistical Agency projected population for 2019).

2 World Population Review. Africa Population, 2019. Retrieved 12 May 2019 from: <http://worldpopulationreview.com/continents/africa-population/>



1.

THE NATIONAL CONTEXT

1.1. Ethiopia's progress toward the Sustainable Development Goals

Ethiopia was successful in achieving almost all of its Millennium Development Goals by 2015 and is now responding to the global mandate to achieve 17 Sustainable Development Goals (SDGs) by 2030.^{3,4}

The country's second Five-Year Growth and Transformation Plan 2015/2016-2019/2020 (GTP II) is the overarching road map for Ethiopia's development, and its 10 national development priorities are aligned with the 17 SDGs.⁵ With aspirations to become a low-middle-income country by 2025,⁶ the national landscape is replete with pro-poor policies, strategies, plans and programmes that can benefit women, children and adolescents, and there have been improvements in some SDG indicators (Table 1).⁷ However, Ethiopia is still classified as a 'low human development' country (**Box 1**).⁸ As will be examined in subsequent sections of this report, there

3 National Planning Commission and the United Nations in Ethiopia. 2015. Millennium Development Goals Report 2014. Ethiopia: Assessment of Ethiopia's Progress towards the MDGs.

4 United Nations. 2016. About the Sustainable Development Goals. Retrieved from <https://www.un.org/sustainabledevelopment/sustainable-development-goals/>

5 Federal Democratic Republic of Ethiopia. Growth and Transformation Plan II (GTP II), 2015/16-2019/20. Volume I: Main Text.

6 Ibid.

7 Federal Democratic Republic of Ethiopia Central Statistical Agency. 2017. Sustainable Development Goals Ethiopia Fact Sheet, July 2017.

8 United Nations Development Programme. 2018. Human Development Indices and Indicators: 2018 Statistical Update.

are persistent disparities, and SDG-related progress varies across sectors. Thus, there is an unfinished agenda in ensuring truly inclusive pathways toward sustainable development in Ethiopia.

Box 1.

SELECTED HUMAN DEVELOPMENT INDICATORS, ETHIOPIA

Human Development Index ranking: Has consistently risen between 2000 (.283) and 2017 (.463), but the country ranks 173rd out of 189 countries in terms of human development

Life expectancy at birth: Has consistently increased and now stands at 65.9 years

Gross National Income per capita: \$1,719

Percentage of the population living below the national (monetary) poverty line: Still high (23.5%) although vastly lower than it was 20 years ago (43.5%)

Multi-dimensional child poverty (MCP) rate: 88%

Urbanization rate: 20.3%

Sources: For MCP rate: CSA and UNICEF Ethiopia (2018): Multi-dimensional Child Deprivation in Ethiopia. For all other indicators: United Nations Development Programme (UNDP). 2018. Human Development Indices and Indicators: 2018 Statistical Update.

1.2. Political economy and a changing socio-political context

In recent years, Ethiopia has undergone potentially transformative events within the socio-political landscape. The swearing in of Prime Minister Dr. Abiy Ahmed in April 2018, coupled with the subsequent election of Ethiopia's first female President, Sahle-Work Zewde, in October 2018, has ushered in a new era of governance and potential for reforms that can benefit women and children.

The country's historical narrative is rooted in the concept of Ethiopian exceptionalism, and both religious and traditional beliefs underlie assertions of authority and power.⁹ As a country with multiple constituencies at both federal level and within regions, social cohesion

9 Rift Valley Institute. 2019. Ethiopia Under Abiy: An age of uncertainty and opportunity, March 2019.

issues persist.¹⁰ Greater political representation and control over land and resources have been drivers of large-scale anti-government protests (specifically in Oromia) that actually led to the declaration of a state of emergency in 2016 and 2017. In 2018, unrest and conflict extended to other parts of the country, such as the Southern Nations, Nationalities and Peoples (SNNP) region (Gedeo zone), and along the Benishangul-Gumuz and Oromia regional border.^{11, 12}

The placement of children and adolescents within the changing landscape is unclear. Identity- and demography-based politics are still a palpable aspect of the national context, and age-based exclusion of younger Ethiopians from social, economic and political processes is evident.¹³ Inclusive growth and development will require careful management and amelioration of deep-seated ethno-political tensions—a realistic threat to stability in present-day Ethiopia—to create a secure, stable nation for Ethiopia's children. Reforms will need to entail the introduction and/or expansion of platforms and opportunities that optimize youth development and facilitate their participation in development processes that not only shape the current national context but can positively alter the country's path for generations to come.

1.3. Population dynamics that impact children and women

Demographic changes will dramatically shape the world in which women, children and adolescents live. Unpacking complex population dynamics that exist within the country will shed light on: (a) the nature and concentration of need, and (b) the types of service delivery modalities that need to be considered to optimize the well-being of all women, children and adolescents.

10 United Nations Economic Commission for Africa. 2019. Social Cohesion in Eastern Africa. Available at https://www.uneca.org/sites/default/files/PublicationFiles/social_cohesion_in_eastern_africa_fin_eng.pdf.

11 United Nations Office for the Coordination of Humanitarian Affairs. 2018. Ethiopia: Overview of recent ongoing inter-communal violence and displacement, No. 2, 22 October 2018, pp. 1-4.

12 Economic Intelligence Unit. 2018. Country Report Ethiopia 2018, pp. 2, 4.

13 Ibid.

Table 1. Ethiopia's progress on selected SDG indicators

SDG indicator	Baseline (2014/15)	National target (2019/20)	Latest status
SDG-1: Ending Poverty			
National Poverty Rate (%)	23.5	16.7	unknown
Gov. expenditure for institutions benefitting women, the poor, the vulnerable (share of GDP as %)	17.3	22.6	18.4 (2015/16)
Multi-dimensional child deprivation (MCD) rate	90	--	88
SDG-2: End Hunger			
Major food crop production (in millions of quintals)	270.08	406	unknown
No. of households (farmers) who obtained improved agricultural extension services (in thousands)	14,014	18,237	14,549 (2015/16)
Under-five stunting rate (%)	40	26	37 (2019)
Under-five wasting rate (%)	9	4.9	7 (2019)
SDG-3: Healthy Lives and Well-being			
Maternal mortality ratio per 100,000	420	199	412 (2016)
Under-five mortality per 1,000	64	30	55 (2019)
Neonatal mortality rate per 1,000	28	10	30 (2019)
SDG-5: Gender Equality			
Percentage of women in Parliament	38.8	50	unknown
No. of women who received certificates of Land Use Rights	8,647,118	19,869,312	12,086,907
Percentage of women 15-49 years who agree that a husband is justified in hitting or beating his wife for at least one specific reason	68.4	--	63
Percentage of men 15-49 years who agree that a husband is justified in hitting or beating his wife for at least one specific reason	27.6	--	44.7
Percentage of women aged 20-24 years married before age 18	41	--	40.3
SDG-16: Peace, Justice and Strong Institutions			
Proportion of children under 5 years of age whose births have been registered with a civil authority (%)	2.7	--	2.7

Data sources: (1) For MCD rate: Central Statistical Agency (CSA) and UNICEF Ethiopia 2018. Multi-dimensional Child Deprivation in Ethiopia; (2) For SDG indicators on age of marriage (SDG 5): 2011 and 2016 Ethiopia Demographic and Health Survey; (3) For latest estimates on stunting, wasting, under-five mortality and neonatal mortality: Ethiopian Public Health Institute [Ethiopia] and ICF. 2019. Ethiopia Mini Demographic and Health Survey; (4) For all other indicators: Federal Democratic Republic of Ethiopia. 2017. Ethiopia 2017 Voluntary National Review on SDGs: Government Commitments, National Ownership and Performance Trends. National targets for indicators obtained from: CSA. 2017. SDG Factsheet for Ethiopia.



A GROWING POPULATION OF NEED—The country's annual population growth rate is estimated at 2.85 per cent, the 11th highest growth rate in the world.¹⁴ With this rapid rate of growth, Ethiopia's population will double in size by 2050.¹⁵ Thus, already-overstretched systems and structures will be further challenged in an attempt to respond to the magnitude of children, adolescents and women living in Ethiopia in the coming decades. Total fertility rates are much higher in rural areas than in urban areas (on average, 5.2 and 2.3 children per woman, respectively), and they are twice as high among the poorest women than among the richest women (on average, 5.6 and 2.6 children per woman, respectively).¹⁶ These are important differentials to consider as drivers of rapid population growth. Revisiting the notion of political economy, and considering broader issues of inclusion and access to resources and power, population growth and fertility cannot be delinked from the ethno-federal model of governance that has historically existed in Ethiopia. Consideration of why regions such as Somali (and to a lesser extent, Afar and Oromia) have lagged in fertility reduction relative to other parts of the country might be due, in part, to limited service access, availability and/or quality. Issues regarding mode of living (e.g., pastoralist lifestyle), gender and social norms, and political economy also warrant further consideration.

CONTINUED URBANIZATION—The issue of urbanization was highlighted in the previous Situation Analysis. Ethiopia's total population in 2019 is estimated at 98,665,000,¹⁷ with 21 per cent of the population currently residing in urban areas—far lower than the global rate of urbanization (55 per cent).¹⁸ The country is, however, on an upward trajectory in terms

of urbanization, and by 2037, 31 per cent of Ethiopia's population is projected to be urban.¹⁹ Rural-urban migration is a major contributor to urbanization in Ethiopia, and the majority of urban growth is occurring in smaller cities and towns with fewer than 300,000 inhabitants, not in large cities.²⁰ According to the World Bank, this internal migration pattern accounted for 41 per cent of Ethiopia's total urban population increase in 2018. Out-of-school adolescent girls constitute one of the largest groups of internal migrants in Ethiopia.²¹

There is regional variation in urbanization rates, with Somali and SNNP regional states each having the lowest urbanization rates at present (14 per cent) and in the future (projected to be 16 per cent to 18.6 per cent and 19.7 per cent to 24.6 per cent, respectively in 2037).²²

There is merit in revisiting urbanization projections in light of humanitarian factors. More specifically, considering population displacement resulting from a multitude of humanitarian crises (see Section 1.7), and the establishment of resettlement camps near urban and peri-urban areas, urbanization estimates and projections might not sufficiently factor in displaced persons and other populations on the move who are migrating to urban/peri-urban settings.²³

As a potential engine for economic growth, urbanization is very much a positive phenomenon. However, the impact of urbanization and other demographic changes may have different implications for different sub-sets of children, as described in the section on Adolescents (Section 2.7).²⁴ Given

14 Central Intelligence Agency. 2018. CIA World Factbook: Ethiopia population growth rate. Updated 20 January 2018, Retrieved 1 May 2019, from <https://www.cia.gov/library/publications>.

15 Alemayehu, B. and Yihune, L. 2014. Projecting Ethiopian Demographics from 2012-2050 Using the Spectrum Suite of Models. Health Policy Project.

16 Central Statistical Agency and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia and Rockville, Maryland, USA: Central Statistical Agency and ICF.

17 Central Statistical Agency. 2013. Population Projections for Ethiopia, 2007-2037.

18 United Nations Department of Economic and Social Affairs, Population Division. 2018. World Urbanization Prospects: The 2018 revision. Files 1 and 3.

19 Central Statistical Agency. 2013. Population Projections for Ethiopia, 2007-2037.

20 United Nations Department of Economic and Social Affairs, Population Division. 2018. World Urbanization Prospects: The 2018 revision. File 1. UNICEF. 2017. Generation 2030. Africa 2.0. Prioritizing Investments in Children to Reap the Demographic Dividend, p. 64.

21 Erulkar, Annabel, Girmay Medhin and Lemi Negeri. 2017. The Journey of Out-of-School Girls in Ethiopia: Examining migration, livelihoods and HIV. Addis Ababa: Population Council.

22 Ibid.

23 UNICEF Ethiopia. 2013. Urban Concept Note. Density greater than 150 people per km², and are located within one-hour travel time from a city of at least 50,000 people.

24 Erulkar, Annabel, Girmay Medhin and Lemi Negeri. 2017. The Journey of Out-of-School Girls in Ethiopia: Examining migration, livelihoods, and HIV. Addis Ababa: Population Council.

current urbanization trends, children from rural areas may have even further-diminished livelihood options when they compete in the labour market against better-educated, better-equipped urban counterparts, further widening the rural-urban divide vis-à-vis inclusive growth and development.²⁵ There is, however, a paucity of data and information on the impact of urbanization on rural populations of children and women, particularly when considering the cost-efficiency implications of providing high-impact services and interventions to less-densely populated parts of the country that are not undergoing an urban boom.

THE DYNAMICS OF INTERNAL AND EXTERNAL MIGRATION

— Migration is an ever-present phenomenon in Ethiopia, driven by both ‘push’ and ‘pull’ factors.^{26, 27} Climate-related migration due to issues such as water stress and/or crop failure is an example of a prominent push factor.^{28,29} Additional push factors include political instability, conflict and the lack of, or disruption to, educational and/or livelihood opportunities.³⁰ The labour market or better livelihood prospects are common pull factors, both for internal and external migration.³¹

Although migration experiences and the drivers are not uniform across all groups or areas in Ethiopia, gender norms are also at play as push factors, with some girls migrating to places such as the Middle East to generate income and send remittances to their families

in Ethiopia.³² As will be described later in this report, this phenomenon can expose females to risks of violence, mistreatment and/or exploitation.

Considering the specific implications of internal and external movement on children, the globally recognized concept of ‘children on the move’ (**Box 2**) has seen increased focus in recent years. In some regards, while certain sub-groups of children on the move (e.g., pastoralists, agro-pastoralists, street children) can be fairly ‘visible’ to the government and its development partners, other sub-sets of children on the move are virtually invisible (particularly children whose movement is rooted in mistreatment, abuse and/or exploitation (e.g., trafficking, exploitative work).

The limited availability and quality of data on the magnitude, vulnerabilities, needs and outcomes of children on the move was

Box 2.

EXPANDING OUR VIEW OF ‘CHILDREN ON THE MOVE’

‘Children on the move’ have emerged as a highly salient sub-set of children in Ethiopia. A conventional definition of children on the move includes internally displaced, asylum seeker and refugee children, migrant children of families seeking better economic, educational or social opportunities, and trafficked children.

However, in Ethiopia, pastoralist children can also be regarded as a unique sub-population group, given their mobile lifestyle.

The status, vulnerabilities and needs of children on the move are further examined in the chapter on Child Protection.

Sources: UNICEF ESARO. 2017. Protecting Children on the Move in Eastern and Southern Africa, Concept Note, Oct. 2017, p. 3. See also Save the Children and RMMS, *Young and on the Move. Children and Youth in Mixed Migration Flows within and from the Horn of Africa*, 2016, p. 19.)

25 Ibid.

26 Mixed Migration Centre. 2018. Experiences of Female Refugees & Migrants in Origin, Transit and Destination Countries. A Comparative Study of Women on the Move from Afghanistan, East and West Africa, Sept. 2018, p. 22.

27 Save the Children and RMMS, *Young and on the Move. Children and Youth in Mixed Migration Flows within and from the Horn of Africa*, 2016, pp. 31-42.

28 The World Bank Group (Rigaud et al.). 2018. Groundswell: Preparing for internal climate migration, p. 126.

29 Akumu and Frouws (Mixed Migration Centre), *Drought: A contributing or limiting factor in migration?* 2017, available at: <http://www.mixedmigration.org/articles/drought-a-contributing-or-limiting-factor-in-migration/>.

30 Ibid.

31 International Labour Organization. 2017. *Migration and Forced Labour: An analysis on Ethiopian workers*, p. xvi, with a reference to Kuschminder and Siegel, 2014.

32 Overseas Development Institute (Jones). 2014. *Rethinking the ‘Maid Trade’: Experiences of Ethiopian adolescent domestic workers in the Middle East.*

highlighted in a 2018 call to action.³³ However, there is some documentation of risks faced by cross-border children on the move (e.g., forced labour, irregular payment of salary or denial of salary, mistreatment, passport confiscation, kidnapping, sexual abuse and other adverse outcomes).^{34,35}

THE DEMOGRAPHIC DIVIDEND—Ethiopia is at a critical juncture in its national development, when the potential to reap the demographic dividend—accelerated economic development as a result of changes in the population age structure, coupled with declines in mortality and fertility—has never been higher.^{36,37} However, doing so requires a significant investment in adolescents (defined by the United Nations as persons between the ages of 10 and 19) and young people.³⁸

While Ethiopia's current population is quite young, the proportion of the total population aged under 15 years is expected to decrease, largely due to the declining fertility rate.³⁹ As highlighted in **Box 3**, there is a need to redouble efforts to yield a demographic dividend. Adolescent development and participation has a dedicated chapter in this report, where many of the factors that are

Box 3.

IS ETHIOPIA PREPARED TO REAP THE 'DEMOGRAPHIC DIVIDEND'? ILLUSTRATIVE CONSIDERATIONS

Increased investment and tailored programming in education across the entire span of childhood and adolescence ✓

Social services that are tailored to young people and brought to scale ✗

Active engagement and meaningful participation of children and youth in planning and implementing programmes/services ✗

important to the demographic dividend are examined.

1.4. Equality and social inclusion

To fully appreciate the extent to which the country has made progress in relation to the SDGs and the demographic dividend, the situation of women and children must be examined through an equity lens. Despite laudable macro-level achievements, there is evidence that the poorest and most vulnerable population groups have benefitted least from development gains.⁴⁰ This reality is highly salient in light of findings from a recent analysis that identified household wealth, in addition to other factors such as region, area of residence and paternal education, as being positively associated with child well-being outcomes.⁴¹ The findings from regression analyses show that children residing in regions other than Addis Ababa are more likely to have negative well-being outcomes. Similarly, residing in rural areas is negatively associated with children's well-being, especially health and education. Household wealth, on the other hand, was found to be positively associated with child well-being outcomes. Paternal educational attainment positively correlates with children's outcomes in education and health-related knowledge. The gender of the child shows no statistically significant

33 UNICEF. 2018. A Call to Action: Protecting children on the move starts with better data. Retrieved from https://data.unicef.org/wp-content/uploads/2018/02/Migration_advocacy_Feb20.pdf

34 United States Department of State. 2018. Human Trafficking Report, Ethiopia, 2018, pp. 184-185. See for example, <http://www.hrw.org/news/2014/05/25/yemen-migrants-held-torture-camps>.

35 International Labour Organization, Promote Effective Labour Migration Governance in Ethiopia, 2017, p. 12. For example, in January 2018 at least 30 people drowned off the coast of Yemen when an overcrowded boat capsized after smugglers opened gunfire on the passengers.

36 Admassie, Assefa, Nuru, Seid, May, John and Megquier, Shelley. 2015. The Demographic Dividend: An opportunity for Ethiopia's transformation. Ethiopian Economics Association and Population Reference Bureau. Retrieved from https://www.gatesinstitute.org/sites/default/files/15-278_EthiopiaEarlyInsights_FINAL.pdf

37 Gribble, James, N. and Jason Bremner. 2012. 'Achieving a Demographic Dividend', Population Bulletin 67, No. 2 Washington, D.C.: Population Reference Bureau.

38 United Nations Department of Economic and Social Affairs, Population Division. 2018. World Urbanization Prospects: The 2018 revision, File 1. UNICEF. 2017. Generation 2030. Africa 2.0. Prioritizing Investments in Children to Reap the Demographic Dividend, 2017, p. 64.

39 Central Statistical Agency. 2013. Population Projections for Ethiopia, 2007-2037.

40 The annualized growth in per capita real survey mean consumption or income between 2010/11 and 2015/16 was 1.7 per cent for the bottom 40 per cent compared to 4.9 per cent of the total population. World Bank WDI.

41 SPRI Global. 2019. Trends of Change on Gender Equality and Women's Empowerment and its Relationship to the Well-being of Children in Ethiopia.

association with child well-being in Ethiopia. Prominent dimensions of equity and social inclusion impacting the welfare of children and women relate to: gender equality; a sub-set of four regions that have historically lagged behind the rest of the country on various indicators; pastoralists; poverty; and persons with disabilities.

1.4.1. Gender equality

A recent study on gender equality and its relationship to child well-being in Ethiopia found that women's empowerment correlates strongly with child well-being. More specifically, a child of an empowered mother is less likely to be deprived in education, nutrition and health-related knowledge.^{42,43} Thus, achieving gender equality and women's empowerment in Ethiopia should be regarded as an important element in improving the situation of children and adolescents.

Gender equality is being mainstreamed across a number of sectors in Ethiopia. The 1995 Constitution of the Federal Democratic Republic of Ethiopia is the umbrella law that articulates the rights conferred on all Ethiopians, regardless of gender. There are

additional legal frameworks, such as the Women's Policy and Strategy and Women's Development Package (2016), which contribute to an enabling environment to address gender equality. However, there are key operational considerations to make transformative and sustainable strides related to gender equality. The Ministry of Women, Children and Youth (MoWCY) is a focal institution that should lead cross-sectoral efforts related to gender equality. Ensuring that MoWCY has the necessary cross-sectoral mandate, resourcing and institutional capacity to lead efforts and monitor outcomes related to gender equality is crucial for effective gender mainstreaming in Ethiopia.

In 2017, Ethiopia ranked 121st out of 160 countries assessed using the UN Gender Inequality Index, a composite measure that measures gender inequalities vis-à-vis reproductive health, empowerment and economic status.⁴⁴ As will be described in later sections of this report, there have been positive shifts in narrowing the gender divide for some key outcomes (e.g., child malnutrition), while others that are deeply rooted in social and gender norms (e.g., secondary school attendance, child spacing) have been slower to improve.

At a macro level, women's civic and labour participation is achieving gender equality. Female employment rates have risen from 64 per cent in 2000 to 71 per cent in 2016, however women are still less likely than men to be employed (2016 male employment rate: 85 per cent).⁴⁵ This pattern holds true at younger ages, for example, among 15- to 24-year-olds.

There are disparities in gender equality and women's empowerment. For example, an analysis of women's empowerment based on 2016 EDHS data found that rural women in a union (married or cohabiting) are much less empowered than urban women in union (2 per cent and 27 per cent, respectively). Empowerment of women in union is highest in Addis Ababa (34 per cent), followed by



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42 Ibid.

43 In the analysis (SPRI Global, 2019), women's empowerment was assessed by grouping 12 indicators into the following four domains: (1) education (literacy and educational attainment), (2) economic (employment status), (3) familial/interpersonal (participation in various decisions) and (4) attitudes towards wife beating.

44 United Nations Development Programme. 2019. Table 5: Gender Inequality Index. Retrieved from <http://hdr.undp.org/en/composite/GII>, 30 May 2019.

45 SPRI Global. 2019. Trends of Change on Gender Equality and Women's Empowerment and its Relationship to the Well-being of Children in Ethiopia.

Harari (13 per cent), and lowest in Somali, Benishangul-Gumuz and SNNP (1 per cent, 3 per cent and 4 per cent, respectively).^{46,47}

There are persistent inequities in the empowerment of women in union across wealth quintiles. Data show that progress in women's empowerment has occurred almost exclusively among women in the richest wealth quintile.⁴⁸ In contrast, there was almost no empowerment and limited progress among the poorest women.

Other aspects of women's empowerment are explored in subsequent chapters. Meaningful changes in gender equality will rely on: (a) redoubling grassroots efforts (with support from UN agencies and development partners) and (b) promoting multi-stakeholder, multi-sectoral action to increase girls' and women's educational attainment, improve their health and survival, and protect children and women from gender-based violence and harmful practices, such as child marriage and female genital mutilation (FGM). Achieving gender equality in Ethiopia must involve both men and women, and must address the way issues of gender are reflected in how services and interventions are implemented; for example, looking at gender balance in service providers, and deep-seated gender norms or stereotypes that might influence how grassroots actors, such as the police, respond to gender-based violence and/or address other manifestations of gender inequality, not just what services or interventions are implemented. Engaging all members of society in efforts to promote gender equality is particularly salient given the gender gap in issues such as gender-based violence. Notably, higher percentages of adolescent girls and adult women (37 per cent to 44 per cent) share the opinion that beating one's wife is justified in certain situations, whereas 13 per cent to 20 per cent of adolescent boys and adult men hold that

opinion.⁴⁹ Thus, there is a need to shift social beliefs and attitudes among females, as well as males. There is a need to safeguard the rights of specific sub-groups of women, such as women and girls with disabilities, as noted by the UN Committee on the Rights of Persons with Disabilities.⁵⁰

Tracking progress in gender equality requires solid data. Gender disaggregation of available data is now an institutionalized practice in some sectors (health and education). Household surveys such as the EDHS include modules on violence, child marriage and FGM, however there remain evidence gaps on the dynamics and drivers of gender-based violence and other dimensions of gender equality.

1.4.2. Special support for selected regions

Gender is not the only salient dimension of equality and inclusion; in Ethiopia, geography is an important correlate of equality and inclusion. Four regions, Afar, Benishangul-Gumuz, Gambella and Somali, have a long-standing history of lagging behind the rest of the country on development indicators. The GTP II calls for broad-scale, special support to these regions as part of human and technology capacity building, although it does not outline explicit strategies or priorities in reference to those regional states.⁵¹ Some sectors, for example education and health, have strategic priorities or special mechanisms to address the needs of the four regions. Component 4 of the Fifth Education Sector Development Programme (ESDP V) focuses on elevating educational attainment across the four regions to be on par with the rest of the country. The Federal Ministry of Education (FMOE) established the Special Support and Inclusive Education Directorate to support the four regions. It has also employed special service delivery models, for example alternative basic education to provide

46 In the analysis (SPRI Global, 2019), women's empowerment was assessed by grouping 12 indicators into the following four domains: (1) education (literacy and educational attainment), (2) economic (employment status), (3) familial/interpersonal (participation in various decisions) and (4) attitudes towards wife beating.

47 SPRI Global. 2019. Trends of Change on Gender Equality and Women's Empowerment and its Relationship to the Well-being of Children in Ethiopia (Policy Brief).

48 Ibid.

49 Ibid.

50 United Nations Committee on the Rights of Persons with Disabilities. 2016. Concluding Observations on the Initial Report of Ethiopia. Adopted by the Committee at its sixteenth session, 15 August-2 September 2016, CRPD/C/ETH/CO/1.

51 National Planning Commission. 2016. Growth and Transformation Plan II (GTP II) (2015/16-2019/20). Volume I: Main Text.

services to under-served population groups, such as pastoralists.⁵² The Federal Ministry of Health (FMOH) established the Pastoralist Health Promotion and Disease Prevention Directorate to provide special support in the four regions.⁵³ There have been donor-funded health sector efforts to introduce innovations (e.g., mobile health clinics) to improve specific outcomes in relation to reproductive, maternal, newborn and child health (RMNCH).⁵⁴

Notably, the nomenclature used to describe the above geographies varies. For example, in some instances the unique dynamics and needs of some of those regions (e.g., Afar, Somali) are addressed under pastoralist programmes. In other instances, the four regions comprise a portion of a larger group of regions classified as ‘lowland’ areas. A 2013 World Bank-funded vulnerability study identified the lowlands as Ethiopia’s poorest, most-vulnerable agro-ecological zone.⁵⁵ The humanitarian-development nexus is quite apparent in lowland areas, which are also hotspots of humanitarian need.⁵⁶ Momentum is growing to direct attention and resources to lowland resilience, for example under the auspices of a Lowland Resilience Strategy and donor-supported initiatives focusing on specific needs (e.g., livelihoods, WASH) in lowland areas. Afar, Gambella and Somali have shown the largest decline in poverty in the country since 2010/2011. However, as will be examined in later sections of this report, poverty exists in many forms, and these regions, particularly Afar and Somali, continue to lag behind with respect to key outcomes for children, adolescents and women.

52 Federal Ministry of Education/Federal Democratic Republic of Ethiopia. 2015. Education Sector Development Programme V (ESDP V), 2008-2012 E.C. 2015/16-2019/20 G.C.

53 Federal Ministry of Health/Federal Democratic Republic of Ethiopia. 2019. Health System Special Support. Retrieved from <http://www.moh.gov.et/ejcc/en/health-system-special-support>.

54 Retrieved 29 May 2019 from <https://www.mottmac.com/article/59623/real-world-evaluation-of-ethiopias-under-served-communities>.

55 Vargas Hill, R. and Porter, C. 2013. Vulnerability Study to Assist with Assessment of Potential Caseload for Next Generation of PSNP & HABP.

56 United Nations. 2019. Humanitarian Response Plan. 2019.

1.4.3. Pastoralists

To achieve equity-focused and inclusive development and growth, the special needs and realities of pastoralists, who are largely concentrated in Somali, Afar and lowland areas of Oromia and SNNP, must remain at the core of both humanitarian and development efforts.

There are many mediating factors related to the vulnerabilities and needs of pastoralists (Box 4). Weak social services (e.g., health, education, protection) and low human capital characterize most pastoral settings.⁵⁷ There

Box 4.

THERE ARE IMPORTANT MEDIATING FACTORS TO CONSIDER IN ADDRESSING VULNERABILITIES AND NEEDS AMONG PASTORALISTS

Pastoral areas are characterized by historically high fertility rates (on average, 5.5 children per woman)(1)

Pastoralists live in ecological zones—arid and semi-arid lowland plains—that are often disproportionately impacted by climate-induced hazards

Differentiating factors among pastoralists include wealth and livestock ownership—both of which can positively impact their coping capacity in response to shocks(2)

The ethno-federal model/dynamics that exist in Ethiopia contribute to reticence on the part of some groups to leave their ethnic territories for other parts of the country(2)

Sources: (1) CSA [Ethiopia] and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF. (2) Helland, J. 2015. Afar Resilience Study. CMI Working Paper, WP 2015:6. Conducted for Feinstein International Center (Tufts University, USA) and Afar Region Disaster Prevention, Preparedness and Food Security Coordination Office, Afar Regional State, Ethiopia.

57 The World Bank Group and the UK Department for International Development (DFID). 2019. ‘Poverty and Vulnerability in the Ethiopian Lowlands: Building a more resilient future. Executive summary’. {Draft}

are implementation challenges to ensuring equitable access to essential services for children and women, social and gender norms that underlie harmful practices, and declining livelihoods resulting from scarce natural resources, such as water and land for grazing. Tailored strategies for pastoralists must recognize their way of life, for example mobility and clan-based social structure, rather than impose 'solutions' that have proven effective in agrarian contexts, such as fixed/static service delivery.

1.4.4. Poverty

In addition to gender and geography, poverty is another correlate of equity and inclusion. According to the CRC, all nation-states are

mandated to ensure a standard of living adequate for children's physical, mental, spiritual, moral and social development.⁵⁸ The share of the population living below the national poverty line in Ethiopia halved between 1995/1996 (45.5 per cent) and 2015/2016 (23.5 per cent). However, one out of every four residents of Ethiopia, which equates to roughly 24 million people, can be classified as absolute poor.⁵⁹ Children bear a greater poverty burden than adults: 32.4 per cent of children under 18 compared with 29.6 per cent of adults are monetarily poor in 2011.^{60,61}

In addition, monetary poverty is higher in rural areas (26 per cent) than in urban areas (15 per cent).⁶² The highest monetary poverty rates are in Tigray (27 per cent), Benishangul-Gumuz (27 per cent) and Amhara (26 per cent), while the lowest rate is found in SNNP (21 per cent).

Monetary poverty estimates only paint a partial picture of child deprivation. A 2018 UNICEF Ethiopia-commissioned study on urbanization

and child poverty showed that children in two urban centres, Kolfe Keraniyo in Addis Ababa and Kombolcha in Amhara region "define poverty as unmet basic needs for education, health and nutrition, clothing and shelter" (Box 5).⁶³ This child definition of poverty is an example of a nuanced understanding among some children that poverty is not just based on monetary resources.

Box 5.

VOICES OF CHILDREN AND ADOLESCENTS

'A poor child wears teared clothes. She suffers from hunger. Her physical well-being is poor, and her skin is itchy. She collects dumped food from the garbage. She does not have a home and lives on the street. She does not attend school as no one can fulfil her basic needs for school material.' (A young, urban child's definition of 'poverty')

Taken from UNICEF Ethiopia-commissioned research: Overseas Development Institute and Ethiopian Development Research Institute . 2018. Urbanization Trends, Urban Child Poverty and Vulnerabilities in Ethiopia.

Looking beyond the issues of income and consumption, an alarming 88 per cent of children in Ethiopia suffer from multi-dimensional poverty (Box 6).⁶⁴ This rate, which is based on 2016 EDHS data, is not vastly different from the MCD rate derived from 2011 EDHS data (90 per cent).⁶⁵ Rural children have an MCD rate (94 per cent) that is more than double that of urban children (42 per cent).⁶⁶

Figures 1 and 2 illustrate regional differences in MCD rates. In Afar, Amhara and SNNP, 91 per cent of children have deprivations in three to six dimensions. Somali, Oromia and Benishangul-Gumuz are not far behind, with 89 per cent to 90 per cent of children in those

58 According to Article 27 of the CRC, which the Government of Ethiopia ratified in 1991.

59 Federal Democratic Republic of Ethiopia, National Planning Commission. 2017. Ethiopia's Progress Towards Eradicating Poverty: An interim report on the 2015/16 Poverty Analysis Study. The absolute number of poor people is based on UN DESA estimates of the population size.

60 Ibid.

61 Central Statistical Agency and UNICEF Ethiopia. 2018. Multi-Dimensional Child Deprivation in Ethiopia.

62 Ibid.

63 Overseas Development Institute and Ethiopian Development Research Institute. 2018. 'Urbanization Trends, Urban Child Poverty and Vulnerabilities in Ethiopia' (Draft Report), p. 26.

64 UNICEF and Central Statistical Agency of Ethiopia. 2018. Multi-dimensional Child Deprivation in Ethiopia (Policy Brief).

65 Central Statistical Agency and UNICEF Ethiopia. 2018. Multi-dimensional Child Deprivation in Ethiopia.

66 Ibid.

ALMOST 9 OUT OF EVERY 10 CHILDREN IN ETHIOPIA EXPERIENCE MULTI-DIMENSIONAL CHILD DEPRIVATION (MCD)

MCD is defined as deprivation in three to six key dimensions, representing lack of fulfillment of rights or need for basic goods and services

For children under 5 years of age, the key dimensions are: (1) development/stunting, (2) nutrition, (3) health, (4) water, (5) sanitation, and (6) housing. For children aged 5-17 years, the key dimensions are: (1) education, (2) health-related knowledge, (3) information and participation, (4) water, (5) sanitation, and (6) housing.

The MCD rate of rural children (94 per cent) is more than double the MCD rate of urban children (42 per cent)

Based on best-available data (EDHS 2016), of all the dimensions noted above, deprivation in housing and sanitation was the largest contributor to MCD in Ethiopia in 2016

Sources: CSA and UNICEF Ethiopia. 2018. *Multi-Dimensional Child Deprivation in Ethiopia*.

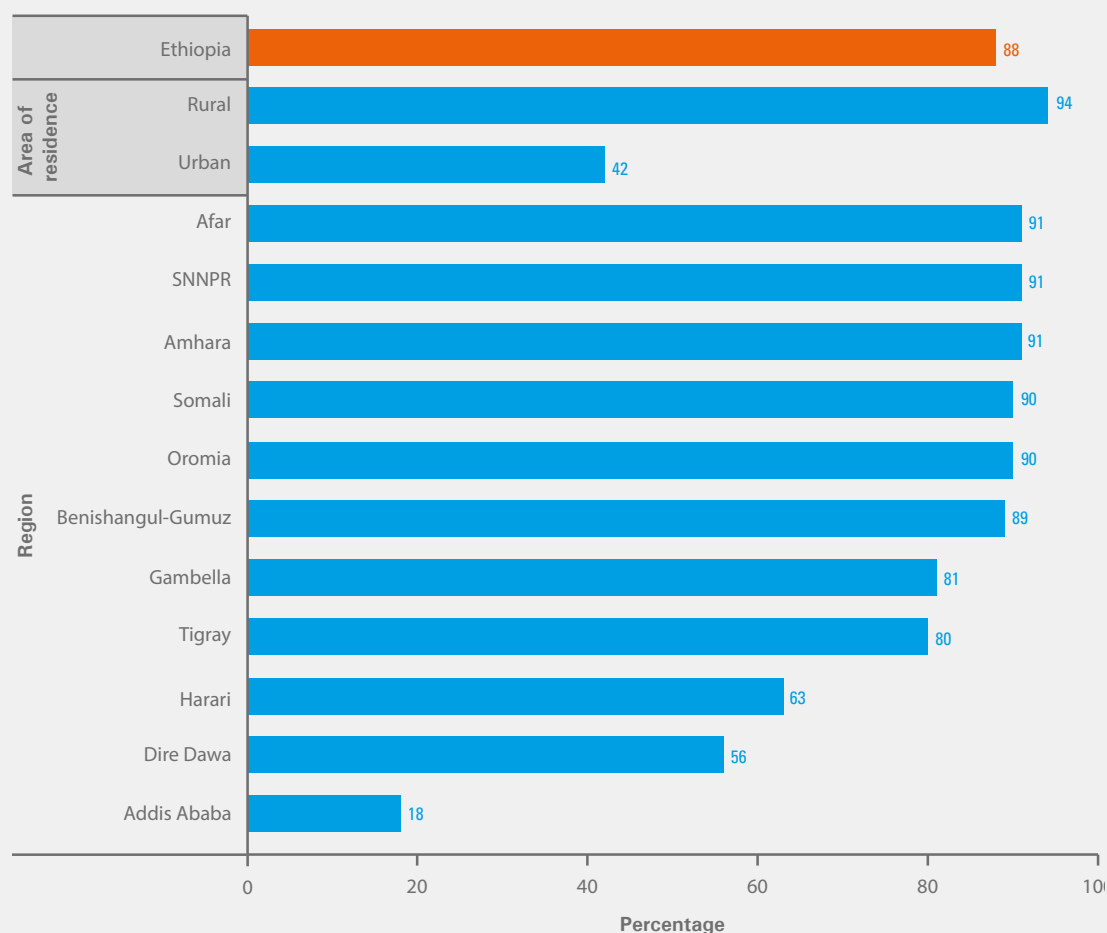
Figure 1. Multi-dimensional Child Deprivation



Source: Central Statistical Agency of Ethiopia and UNICEF Ethiopia, 2018: Multi-dimensional Child Deprivation in Ethiopia.

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Figure 2. Incidence of Multi-dimensional child deprivation

Source: Central Statistical Agency of Ethiopia and UNICEF Ethiopia, 2018: Multi-dimensional Child Deprivation in Ethiopia.

regions having deprivations in three to six dimensions. Children in Addis Ababa have the lowest MCD rate (18 per cent) in the country.

Table 2 and **Figure 3** further examine regional differences according to various dimensions of deprivation, using data from the 2016 EDHS. As stated in the introductory section of this report, there is a degree of imprecision associated with survey estimates, whereby the true value actually lies within a range of possible values. Nonetheless, regional data included in the table are best-available estimates of deprivations vis-à-vis key dimensions of child welfare, and shed light on which regions have the highest (shaded in red) versus lowest (shaded in green) values for each deprivation dimension. In interpreting the table, it should be noted that the colour scheme indicates how regions fare relative to one another on various dimensions, not whether or not the status of a region vis-à-vis


a particular dimension necessitates action. For example, rates of nutrition deprivation are high for all regions, however of all the regions, the rates of nutrition deprivation are highest for Afar and Somali and lowest for Tigray.


There are significant gender disparities in deprivation, particularly for older children and adolescents. For example, 51 per cent of adolescent girls compared with 40 per cent of adolescent boys are illiterate, while 76 per cent of adolescent girls and 64 per cent of adolescent boys are deprived of comprehensive knowledge on HIV/AIDS prevention and transmission.⁶⁷ These two examples highlight the fact that, while multi-dimensional poverty is pervasive among all children, sub-sets of children can be disproportionately affected.

⁶⁷ Central Statistical Agency and UNICEF Ethiopia. 2018. Multi-dimensional Child Deprivation in Ethiopia.

Table 2. Regional comparison of various dimensions of child deprivation in children 5-17 years

Dimension	Key differentials by region:										
	Tigray	Afar	Amhara	Oromia	Somali	B-G	SNNP	Gambella	Harari	Addis Ababa	Dire Dawa
MCD rate, 2016 (national average: 88%)	80	91	91	90	90	89	91	81	63	18	56
Deprivation in physical development/stunted (national average: 37.9%)	38.3	40	47	35.7	26.5	42.5	38.4	23.1	31.6	14.7	39.8
Deprivation in health among under-5s (national average: 68.1%)	37.2	80.1	62.2	78.6	78.1	45.5	65.7	59	57.8	13.5	43
Deprivation in nutrition among under-5s (national average: 72.6%)	59.8	84.6	73.3	74.5	82.4	66.4	71.1	65.9	78.7	62.5	64.2
Deprivation in education (national average: 49.6%)	33.6	55.1	43.1	56.1	58.4	42.2	50.2	32.8	35.6	19.9	36.2
Deprivation in health-related knowledge (national average: 69.3%)	56.7	76.4	64.2	71.5	92.5	77.4	71.9	65.6	72.9	39.3	70.2
Deprivation in information and participation (national average: 65.7%)	50.6	79.4	65.5	64.3	84.6	71	69.2	72.5	70.9	58.9	70.4
Deprivation in water, 0- to 17-year-olds (national average: 57.1%)	47.8	70.3	60.9	54.8	72.5	42.2	63.8	26.9	38.7	2.3	32.8
Deprivation in sanitation (national average: 89.4%)	84.1	88.3	95.4	93.1	70.4	97.2	89.5	89.2	67.7	18.5	50
Deprivation in housing (national average: 88%)	89.6	90.4	92.7	90	84.8	93.3	88.7	85.2	49.3	5.3	50.9

 region(s) with lowest rate of deprivation for the indicator

 region(s) vis-à-vis the highest rate of deprivation for the indicator/dimension

Data Source: CSA and UNICEF Ethiopia. 2018. Multi-dimensional Child Deprivation in Ethiopia. (Original Data Source: 2016 EDHS) B-G = Benishangul-Gumuz.

1.4.5. Persons with disabilities

According to the International Classification of Functioning, Disability and Health, the term 'disability' covers the full spectrum of impairments, activity limitations and participation restrictions.⁶⁸ Best-available data from Ethiopia indicate that approximately 7.8 million people (just under 10 per cent of the total population)

live with some form of disability.⁶⁹ The magnitude of child disability in Ethiopia is difficult to estimate accurately due to the absence surveys, tools or assessments on various aspects of child functioning. Nonetheless, it is estimated that children and youth under the age of 25 constitute approximately 30 per cent of all people with disabilities.⁷⁰

68 World Health Organization. 2001. International classification of functioning disability and health: ICF. World Health Organization. <https://apps.who.int/iris/handle/10665/42407>.

69 Central Statistical Agency/Federal Democratic Republic of Ethiopia. 2019. Household Consumption and Expenditure Survey 2015/16 and Ethiopian Socio-Economic Survey (ESS) 2015/16.

70 Ibid.

Figure 3. Indicator and dimension deprivation rates by area and region of residence

	Water %	Water source %	Distance to water	Sanitation/ toilet type %	Housing %	Housing material %	Indoor pollution%
Ethiopia	57.10	41.30	32.20	89.40	88.80	88.00	31.40
Rural	62.80	46.20	35.10	94.20	94.70	94.50	34.10
Urban	13.90	4.40	10.60	53.40	43.90	39.00	11.00
Dire Dawa	32.80	17.40	29.50	50.00	52.30	50.90	13.70
Addis Ababa	2.30	0.50	1.90	18.50	19.40	5.30	15.30
Harari Region	38.70	26.20	27.50	67.70	50.80	49.30	4.90
Gambella	26.90	19.00	13.20	89.20	85.60	85.20	20.60
SNNPR	63.80	44.40	35.80	89.50	89.20	88.70	43.30
Benishangul-Gumuz	42.20	19.60	27.20	97.20	93.30	93.30	27.30
Somali Region	72.50	59.40	44.70	70.40	85.10	84.80	4.80
Oromia	54.80	42.20	28.00	93.10	90.40	90.00	33.20
Amhara	60.90	42.60	37.00	95.40	93.00	92.70	27.10
Afar	70.30	51.10	54.90	88.30	91.70	90.40	59.10
Tigray	47.80	26.50	33.30	84.10	91.20	89.60	13.40

Source: Central Statistical Agency of Ethiopia and UNICEF Ethiopia, 2018: Multi-dimensional Child Deprivation in Ethiopia.

In Ethiopia, disability can result in or exacerbate poverty due to factors such as lost livelihoods and/or additional costs of living with disability (e.g., additional expenses for medical care, housing and transport). In urban areas, the extreme poverty rate among people with disabilities is 41 per cent higher than that of non-disabled people.⁷¹ Children with disabilities bear a disproportionate burden, having the highest rate of extreme poverty (27 per cent).⁷²

The GTP II identifies people with mental and physical disabilities among priority population groups who should receive special support, such as social protection. The National Social Protection Policy (NSPP) also highlights the need to expand services for persons with disabilities, and there is a National Action Plan for Persons with Disabilities 2012-2021.⁷³ While the action plan outlines various action priorities according to sector, it is limited in terms of special provisions or sub-priorities focused on children with disabilities (with the exception of education). However, other policies, such as the Proclamation Concerning the Rights of Disabled Persons to Employment (2008), the

Ethiopian Building Proclamation (2009), and the Master Plan for Special Needs and Inclusive Education (2016), are notable policy milestones in creating an enabling environment for the inclusion of children and adults with functional limitations.

Despite these strides, Ethiopia's legal and policy landscape vis-à-vis disability still centres on a clinical or medical model approach. In 2016, the UN Committee on the Rights of Persons with Disabilities noted the following for Ethiopia: (1) legislation still includes derogatory language in reference to persons with disabilities; and (2) while there have been strides in reference to employment rights (e.g., Proclamation No. 568 (2008) to provide the right to employment of persons with disability), other aspects of disabled persons' human rights (e.g., legal and social protection) are not sufficiently addressed.⁷⁴

Disability inclusion is thus an issue requiring continued focus and investment. Disability-friendly service provision in social sectors remains limited, and most people with disabilities have sub-par access to services. Civil society has been active in providing services for

71 Central Statistical Agency/Federal Democratic Republic of Ethiopia. 2019. Household Consumption and Expenditure Survey 2015/16 and Ethiopian Socio-Economic Survey (ESS) 2015/16.

72 Ibid.

73 Retrieved from: http://www.ilo.org/dyn/natlex/natlex4.detail%3Fp_lang%3Den%26p_isn%3D94528%26p_country%3DETH%26p_count%3D141

74 United Nations Committee on the Rights of Persons with Disabilities. 2016. Concluding Observations on the Initial Report of Ethiopia. Adopted by the committee at its sixteenth session, 15 August-2 September 2016, CRPD/C/ETH/CO/1.



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people with disabilities, although the focus of non-government organizations (NGOs) and civil society organizations (CSOs) has been largely on physical impairments rather than on the many other forms of disability.

The Ministry of Labour and Social Affairs (MoLSA) is mandated to provide leadership and coordination with respect to vulnerable populations, such as people with disabilities.⁷⁵ However, the extent to which MoLSA is sufficiently resourced (budgetary resources, trained personnel, information systems) to respond to its mandate in reference to people with disabilities is an issue that warrants further attention, in order to strengthen institutional capacity and address operational requirements of disability mainstreaming.

1.5. The macro-economic context

Available evidence paints a complex macro-economic picture for Ethiopia. The country's economic growth has outperformed many countries. Between 1999/2000 and 2016/2017, Ethiopia's Gross Domestic Product (GDP) per capita increased from US\$ 129 to US\$ 863.⁷⁶ 2015/2016 figures show that the country's economy grew by 8 per cent in that fiscal year, which was below its target of 11.2 per cent

growth for the year, but more than three times the average economic growth rate for Sub-Saharan Africa (2.5 per cent in 2015/2016).⁷⁷ However, Ethiopia's rate of growth has slowed slightly in recent years. GDP growth was 10.2 per cent in 2017 (compared with a stagnant rate of growth for Sub-Saharan Africa—still at 2.5 per cent—in 2017, and also higher than the average GDP growth rate of 5 per cent for low-middle-income countries).⁷⁸

Ethiopia's real GDP growth is projected at 9.7 per cent for 2019 and 9.9 per cent for 2020.⁷⁹ However, the country has experienced rising debt levels, with low public saving rates and high public investment being major debt contributors.⁸⁰ Continued depreciation of the Ethiopian Birr (ETB) has resulted in double-digit inflation.⁸¹ All of these economic patterns can have major implications in terms of public finance for children (see Section 1.6), and more broadly, public expenditure to ensure that no vulnerable groups are left behind in Ethiopia's pursuit of sustainable growth and development.

These recent economic trends necessitate closer monitoring, given their potential to impact resource allocation to social sectors and/or increase the burden on the limited number of working-age people in Ethiopia to support children and the elderly (i.e., the 'dependency ratio').

Another consideration is the extent to which the national economy is diversified. Ethiopia's economic growth depends largely on agriculture, which accounted for 39 per cent of GDP in 2014/2015.⁸² As will be discussed in the section on humanitarian issues (Section 1.7), continued economic dependence on agriculture

75 Endale, K., Pick, A. and Woldehanna, T. 2019. OECD Development Policy Papers February 2019 – No. 15, Financing Social Protection in Ethiopia: A long-term perspective.

76 United Nations Development Programme. 2018. Ethiopia National Human Development Report 2018: Industrialization with a human face, available from <https://bit.ly/2DTnnWG>.

77 National Planning Commission. 2017. 'The 2017 Voluntary National Reviews on SDGs of Ethiopia: Government commitments, national ownership and performance trends'.

78 The World Bank. 2019. GDP Growth (Annual %). Retrieved from <https://data.worldbank.org/indicator/ny.gdp.mktp.kd.zg>

79 The World Bank. 2018. Global Economic Prospects, June 2018: The Turning of the Tide? Washington, DC: World Bank. doi: 10.1596/978-1-4648-1257-6. License: Creative Commons Attribution CC BY 3.0 IGO.

80 Ibid.

81 Ibid.

82 United Nations Development Programme. 2018. Ethiopia National Human Development Report 2018: Industrialization with a human face, available from <https://bit.ly/2DTnnWG>.

is a major vulnerability—not just for households that rely on agriculture-based livelihoods, but for the nation as a whole. The GTP II outlines a transition from a primarily rural, agricultural-based economy to a more diversified economy. The country is on a trajectory of industrialization and there are signs of growth in the industrial and services sectors.⁸³ Ethiopia now has a number of industrial parks in locations such as Bole Lemi, Hawassa, Kombolcha and Mekele.⁸⁴ However, the industrial sector is not a major driver of the Ethiopian economy. Remittances from Ethiopians living outside the country are a prominent feature of Ethiopia's economy, accounting for at least ETB 127 billion in 2016.⁸⁵ Yet the limited traction of mobile banking in Ethiopia, coupled with high transfer fees, potentially hinders remittance flows into the current domestic market.

Further complicating the situation is income inequality. Even when the macro-economic data paint a favourable picture, further analysis reveals that benefits do not extend to all

members of society. In Ethiopia, the poorest 40 per cent of the population have the smallest growth rate of income/consumption (1.7 per cent) compared to the top 60 per cent (5.6 per cent) and the top 10 per cent (7.8 per cent) of the population. Another pattern of note is that this gap is widening.⁸⁶ The Gini Index quantifies “the extent to which the distribution of income (or consumption expenditure) among individuals within an economy deviates from a perfectly equal distribution, with a value of 0 representing perfect equality and a value of 100 representing perfect inequality”.⁸⁷ Ethiopia's Gini Index was 33.2 in 2010/2011 and 39.1 in 2015/2016.⁸⁸

1.6. Public finance levels and trends

For the past few decades, Ethiopian authorities have regarded poverty reduction as a cog in ‘unlocking’ development and maintaining national security.⁸⁹ Consequently, social-sector spending, mobilized from both domestic and international resources, has been high. As shown in **Figure 4**, data from multiple rounds of EDHS and finance data from the Ministry of Finance and Economic Cooperation (MoFEC) indicate that between 2005 and 2016, as per capita poverty-oriented public expenditure increased, under-five mortality rates decreased. However, from the perspective of public finance for children, there are issues related to: (1) the overall amount of resources made available for child- and adolescent-sensitive service delivery, (2) how available resources are allocated, and (3) how required resources are mobilized. There is tremendous variation in resource allocation to individual sectors. Out of Ethiopia's total national government expenditure in 2016/2017, education accounted for 26.5 per cent (estimated as equivalent to 45 per cent of GDP), and health accounted for 6.6 per cent.⁹⁰ The country's flagship social protection programme, the Productive Safety Net Programme (PSNP), is also underfunded.⁹¹



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83 National Planning Commission. 2016. Growth and Transformation Plan II (GTP II) (2015/16-2019/20). Volume I: Main Text.

84 United Nations Development Programme. 2018. Ethiopia National Human Development Report 2018: Industrialization with a human face, available from <https://bit.ly/2DTnnWG>.

85 Vivid Economics and Institute of Economic Development. Ethiopia: Sustainable Development Goals Needs Assessment. Report prepared for the Federal Democratic Republic of Ethiopia's National Planning Commission [SOURCE DOCUMENT: Ferede, T. 2017. A Joint Roadmap Between the Government of Ethiopia and DAG for the Implementation of the Addis Ababa Action Agenda.]

86 The World Bank. 2019. Poverty and Equity Data Portal (<http://povertydata.worldbank.org>)

87 Ibid. Description of key indicators.

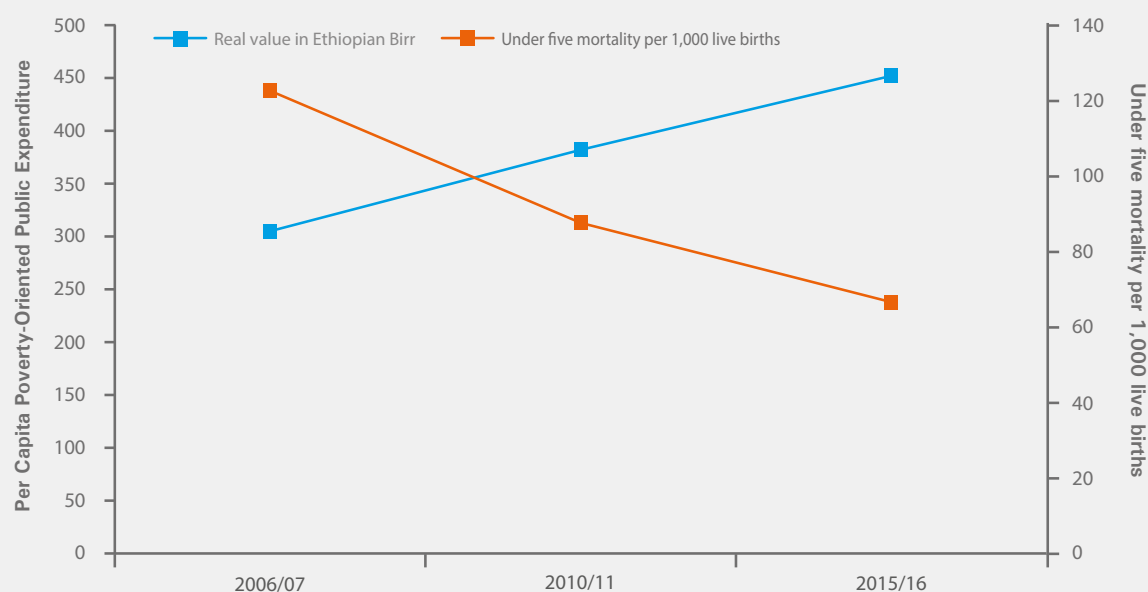
88 Ibid.

89 Rift Valley Institute. 2019. Ethiopia Under Abiy: An age of uncertainty and opportunity, March 2019.

90 UNICEF. 2019. National Budget Brief: Updated with 2016/17 data.

91 UNICEF. 2019. National Social Protection Budget Brief: 2013/14-2017/18.

Figure 4. Under-five mortality rates and per capita poverty-oriented expenditure



Note: Expenditure values are in 2007 real prices. As Ethiopia Demographic Health Survey data for under-five mortality is not available for 2006/07, data from the Ethiopia Demographic Health Survey, 2005 is used as a proxy.

Source: Ethiopia Demographic and Health Surveys, 2005, 2011 and 2016, Ministry of Finance, 2018.

There is evidence of shortfalls in public spending. A 2015 public expenditure review conducted by the World Bank revealed that, while Ethiopia's public spending on health—estimated at US \$21 per capita at the time of the review—has increased, it remains among the lowest in the Africa region.⁹² A 2018 UNICEF-supported SDG financing analysis estimated that achievement of child-sensitive SDGs would require approximately US\$ 230 per capita, per year—far higher than the current estimated investment of US\$ 40 per capita in 2018.⁹³ The same analysis concluded that the requisite increase in expenditure could be feasible, given: (1) Ethiopia's growth trajectory; and (2) the increased government expenditure that usually accompanies a country's transition from low- to middle-income status.⁹⁴ However,

the rate of economic growth is not keeping pace with the rate of population growth, and insufficient per capita investment in social sectors can compromise sustained economic growth and transformation.

UNICEF's analysis of 2016/2017 national spending showed that domestic revenue accounted for 84.2 per cent of the total national revenue, with tax revenue generating 76.5 per cent of domestic revenue.⁹⁵ Given Ethiopia's low tax-to-GDP ratio, there is a need to expand the fiscal space to maximize the use of growing domestic resources to achieve inclusive and sustainable growth and development. There is also a need to diversify the resource base. The GTP II conveys an expectation on the part of the government for the private sector to be a co-financer of the GTP's implementation, but offers little in terms of how that should be achieved.⁹⁶ As noted in the SDG Needs Assessment for Ethiopia,

92 Kiringai, Jane Wangui, Geiger, Michael Tobias, Bezawagaw, Mesfin Girma and Jensen, Leif. 2016. Ethiopia Public Expenditure Review (English). Washington, D.C.: World Bank Group. <http://documents.worldbank.org/curated/en/176471468178145744/Ethiopia-public-expenditure-review>.

93 UNICEF, Economic Policy Research Institute and Zerihun Associates. 2018. Financing the Child-Centred Sustainable Development Goals (SDGs) in Ethiopia.

94 Ibid.

95 UNICEF. 2019. National Budget Brief: Updated with 2016/17 data.

96 National Planning Commission. 2016. Growth and Transformation Plan II (GTP II) (2015/16-2019/20). Volume I: Main Text.

there remain low levels of private-sector development.⁹⁷

Over the past decade, there have been noteworthy shifts in national expenditure, with reallocations of spending from federal to regional state governments. This is consistent with Ethiopia's decentralized mode of governance, and a reorientation from recurrent spending to capital spending, although the share of capital spending in total government expenditure has declined in recent years.⁹⁸ The issue of allocative efficiency is highly salient. Despite sub-optimal—albeit increased—levels of public spending on health, increased allocative efficiency was a contributor to Ethiopia's recent health achievements, although there is still room for improvement with respect to technical efficiency and equitable access to health care.⁹⁹ The issue of decentralization, with a re-orientation of public spending from federal level (historically accounting for 60 per cent of total spending) to regional and woreda levels, is also believed to increase equitable service delivery.¹⁰⁰ Hence, in promoting the concept of public finance for children, it is critical to monitor how budgeted resources are allocated and utilized—not just the overall budget ceiling for different child-sensitive services or sectors.

While there are issues of public financing that apply to individual sectors, one cross-sectoral issue, social protection, requires significant shifts in public financing. Although there has been an increase in government spending on social assistance, Ethiopia's social protection efforts are largely financed by the donor community. It is noteworthy that the share of official development assistance to Ethiopia

declined from 20 per cent of Ethiopia's GDP in 2007 to only 3 per cent in 2016.¹⁰¹ Efforts to expand social-sector spending must consider the feasibility of public revenue keeping pace with economic growth, as well as the impact of the government's fiscal decisions (e.g., higher taxation) on poor and vulnerable groups.¹⁰²

1.7. Hazards and risks: The humanitarian context in Ethiopia

At a macro level, economics is only one factor that shapes the national context. Another factor is hazards and risks. Ethiopia is characterized by cyclical hazards that push the bounds of both household and system resilience. According to the Index for Risk Management, Ethiopia ranks 16th in terms of 'hazard and exposure'.¹⁰³ According to the World Risk Report 2018, Ethiopia's risk position was 69th out of 171 countries and 65th in 2017 (with a rank of 1 signifying most at risk).¹⁰⁴ Although there have been some improvements, sub-optimal coping and adaptive capacities are noted as contributors to the country's vulnerability to risk.¹⁰⁵

In 2019, an estimated 8.86 million people are in need of humanitarian assistance.¹⁰⁶ Children (0-17 years) are disproportionately affected by Ethiopia's humanitarian crises, accounting for 55 per cent of total humanitarian need (4.89 million children with humanitarian need). They also account for more than half of all displaced persons in Ethiopia.¹⁰⁷

97 Vivid Economics and Institute of Economic Development. Ethiopia: Sustainable Development Goals Needs Assessment. Report prepared for the Federal Democratic Republic of Ethiopia's National Planning Commission [SOURCE DOCUMENT: Ferede, T. 2017. A Joint Roadmap Between the Government of Ethiopia and DAG for the Implementation of the Addis Ababa Action Agenda.]

98 UNICEF. 2019. National Budget Brief: Updated with 2016/17 data.

99 Ibid.

100 Kiringai, Jane Wangui, Geiger, Michael Tobias, Bezawagaw, Mesfin Girma and Jensen, Leif. 2016. Ethiopia Public Expenditure Review (English). Washington, D.C.: World Bank Group. <http://documents.worldbank.org/curated/en/176471468178145744/Ethiopia-public-expenditure-review>.

101 OECD. 2019. Financing Social Protection in Ethiopia: A long-term perspective. OECD Development Policy Papers, January 2019, No. 16.

102 Ibid.

103 Inter-Agency Standing Committee (IASC) and European Commission (2019). Index for Risk Management (INFORM) Country Risk Profile: Ethiopia 2019. Available at http://www.inform-index.org/Portals/0/Inform/2019/country_profiles/ETH.pdf. Accessed on May 1, 2019.

104 Bündnis Entwicklung Hilft. 2018. World Risk Report 2018, Focus: Child protection and children's rights. Retrieved from <https://reliefweb.int/sites/reliefweb.int/files/resources/WorldRiskReport-2018.pdf>

105 Ibid.

106 National Disaster Risk Management Commission, Humanitarian Country Team and partners. 2019. Humanitarian Needs Overview.

107 Ibid.; United Nations High Commissioner for Refugees. 2018. Operational Update on Ethiopia, September 2018; ACAPS. 2018. Briefing Note: Displacement in Ethiopia, Oct. 2018.

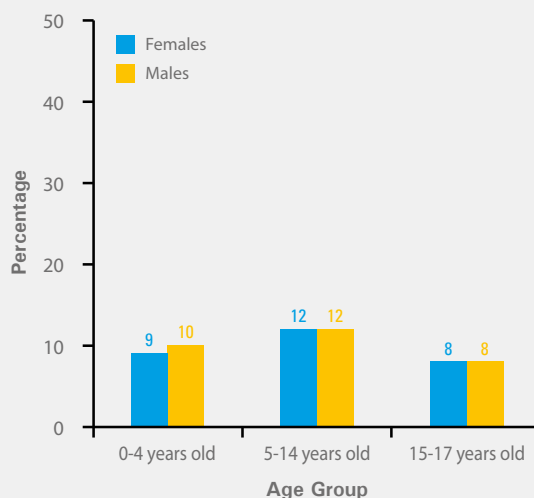
Displaced individuals, whether refugees or internally displaced persons (IDPs), are often regarded as populations of tangible humanitarian need. In reality, the estimated number of people in need of humanitarian assistance who are not displaced (5.67 million exposed to shocks and/or crises but not displaced) exceeds the estimated number of people in need of humanitarian assistance who are displaced (3.19 million)¹⁰⁸ Thus, a nuanced understanding of dynamics and drivers of humanitarian need is essential. According to Ethiopia's Displacement Tracking Matrix, children account for 29 per cent of displaced males and 30 per cent of displaced females, and children aged 5-14 years account for the highest proportion of displaced children (Figure 5).¹⁰⁹

As a country with a relatively progressive open-door policy to refugees, Ethiopia has hosted 655,105 refugees in 2019 (people originating from South Sudan and Somalia accounting for the largest numbers), with Tigray, Afar, Benishangul-Gumuz, Gambella and Somali hosting the majority of refugees.¹¹⁰ Almost two thirds (63 per cent) of documented



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Figure 5. Age and Sex Breakdown of Displaced Children in Ethiopia



Source: Displacement Tracking Matrix, Round 15, 2019.

refugees are under 18 years of age (21 per cent are 0-4 years, 24 per cent are 5-11 years, and 18 per cent are 12-17 years) with 53 per cent of the total being women and girls. Among the refugee population in Ethiopia in early 2019, almost 55,000 refugee children were unaccompanied or separated from their families. Many of them come from Eritrea (17 per cent) and live in camps in Tigray.¹¹¹ Thus, in addition to contending with acute humanitarian needs (e.g., food security), displaced children (including but not limited to children with inadequate parental care) may have urgent protection needs.

Table 3 shows some regional variation in the extent of humanitarian need, however virtually all regions of Ethiopia are affected by recurrent humanitarian crises.¹¹² In an attempt to further unpack the nature of humanitarian need, Table 3 also shows how different humanitarian issues cluster geographically. Although all identified issues and geographical areas require timely, harmonized and effective interventions, strategic prioritization will likely occur based on national impact potential, particularly given limited financial resources. As shown in the last row of Table 3, one criterion might be the sheer numbers of people who are, or could be, affected. For example, Oromia, Amhara

108 National Disaster Risk Management Commission, Humanitarian Country Team and partners. 2019. Humanitarian Needs Overview.


109 International Organization for Migration. Displacement Tracking Matrix: Round 15: January to February 2019. <https://displacement.iom.int/system/tdf/reports/R15%20National%20Dashboard.pdf?file=1&type=node&id=5379>. Accessed May 1, 2019.

110 United Nations. 2019. Humanitarian Response Plan. 2019.

111 United Nations High Commissioner for Refugees. Child Protection Fact Sheet. Ethiopia, Sept. 2018.

112 United Nations. 2019. Humanitarian Response Plan 2019.

Table 3. Regional comparison of various humanitarian circumstances and proportion of total population, 2019

Hazard-Related Characteristic	Tigray	Afar	Amhara	Oromia	Somali	B-G	SNNP	Gambella	Harari	Addis Ababa	Dire Dawa
	 = Region with hazard-related characteristic										
Regions with lowland areas (1)											
Drought hotspots (1)											
Conflict hotspots (1)											
Host to refugees (1)											
Disease outbreak hotspots (1)											
% of national population (2)	6	2	22	38	6	1	20	<1	<1	4	1

Data Sources: (1) National Disaster Risk Management Commission, Humanitarian Country Team et al. 2019. 2019 Humanitarian Needs Overview; (2) CSA. 2013. Population Projections 2007-2037. (% of national population based on CSA projected population for 2019).

B-G = Benishangul-Gumuz.

and SNNP, which each have endured multiple humanitarian crises, account for 80 per cent of Ethiopia's population. Consequently, starting with addressing humanitarian needs in those three regions would likely bode well for mitigating the national impact of humanitarian crises.

Understanding the drivers and deeper causes of humanitarian crises is paramount to humanitarian responses and resilience building. In Ethiopia, displacement is a manifestation of deeper-seated causes. Conflict is the primary driver of internal displacement in Ethiopia. As of March 2019, there were 1,663,396 conflict-affected IDPs, 508,723 climate-induced IDPs (attributable to environmental factors, such as drought, seasonal floods, flash floods and landslides) and 54,990 people displaced due to other factors.^{113,114} However, common hazards such as those noted above are rooted in broader issues that render certain segments of the population, and the country as

a whole, quite vulnerable. Figure 6 depicts the interrelated nature of key drivers of Ethiopia's humanitarian crises, as well as the fact that there are critical underlying and structural causes at play.

1.7.1. Natural hazards and the effects of climate change

Ethiopia is highly vulnerable to extreme weather events. In recent years, climate change has increased the frequency of those events.¹¹⁵ Between 2015 and 2017, severe El Niño and Indian Ocean Dipole-induced droughts impacted eastern, southern and central areas of Ethiopia, with palpable impacts on children (acute food insecurity, malnutrition, disease outbreaks, displacement and death).¹¹⁶ For a country whose economy largely relies on climate-dependent agriculture, the full spectrum of climate-induced hazards, including emerging environmental

113 International Organization for Migration. Displacement Tracking Matrix: Round 15: January to February 2019. <https://displacement.iom.int/system/tdf/reports/R15%20National%20Dashboard.pdf?file=1&type=node&id=5379>. Accessed May 1, 2019.

114 Oxford Policy Management and the Horn Economic and Social Policy Institute. 2018. Generation El Niño: Long-term impacts on children's well-being: Final Report. UNICEF: Ethiopia Country Office.

115 IGAD Climate Prediction and Applications Centre, Greater Horn of Africa Regional Climate Risk and Food Security Atlas, 2018. See also OECD, Climate Resilience in Development Planning: Experiences in Colombia and Ethiopia, 2014, p. 105; and World Bank, Economics of Adaptation to Climate Change. Ethiopia, 2010, pp. xvi and xvii.

116 Oxford Policy Management and the Horn Economic and Social Policy Institute. 2018. Generation El Niño: Long-term impacts on children's well-being: Final Report. UNICEF: Ethiopia Country Office.

threats, must be considered. For example, since 2017, the Fall Armyworm pest has infested over half a million hectares of land in 411 districts of Ethiopia, and one quarter of the 2.6 million hectares of land planted with maize has been devoured.¹¹⁷ Thus, consideration of natural hazards should not be limited to conventional phenomena such as drought or floods.

1.7.2. Social unrest and violent conflict

Conflict is documented as an immediate driver of outcomes, such as displacement, but it can also be preceded by (or related to) other drivers. Extreme weather events, which can affect natural resource availability (e.g., water, arable land) can contribute to competition over scarce resources, consequently fuelling internal conflicts between population groups.^{118,119} Since 2017, violent conflicts in border woredas between Somali and Oromia have disrupted the lives of many women and children, resulting in loss of lives and spurring displacement.

Greater political representation and control over land and resources have been drivers of large-scale anti-government protests (specifically in Oromia) that actually led to the declaration of a state of emergency in 2016 and 2017. In 2018, unrest and conflict extended to other parts of the country, such as SNNP (Gedeo zone) and along the Benishangul-Gumuz and Oromia regional border.^{120, 121}

In addition to this internal unrest and conflict, there is the issue of transnational geo-politics. In July 2018, Ethiopia and Eritrea signed a peace agreement that ended decades of hostility and armed conflict between the two nations. While that high-level agreement is encouraging, factionalism within each country, in addition to growing domestic and international debt and upcoming parliamentary elections, are issues to monitor.¹²² Peace and stability is not a fixed state; one development is the increasing number of Eritrean refugees crossing the border into Tigray since the peace accord.¹²³ In late 2018, the UN Refugee Agency (UNHCR) reported that since the reopening of the northern border, 14,000 refugees had arrived in Ethiopia, of whom 90 per cent were women and children.^{124,125} A new pull factor has emerged: the desire for family reunification after decades of strife between the two countries, made easier by safer border crossings.¹²⁶



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117 Food and Agriculture Organization. 2017. Fall Armyworm Continues to Spread in Ethiopia's Maize Fields. Available at: <http://www.fao.org/ethiopia/news/detail-events/en/c/1028088/>.

118 IGAD Climate Prediction and Applications Centre. Greater Horn of Africa Regional Climate Risk and Food Security Atlas, 2018. See also OECD, Climate Resilience in Development Planning: Experiences in Colombia and Ethiopia, 2014, p. 105; and World Bank, Economics of Adaptation to Climate Change. Ethiopia, 2010, pp. xvi and xvii.

119 UNICEF ESAR, Briefing Note on Climate Change in Eastern and Southern Africa, 2014, pp. 1-6. See also Heidelberg Institute for International Conflict Research, Conflict Barometer 2017, p. 84.

120 United Nations Office for the Coordination of Humanitarian Affairs. 2018. Ethiopia: Overview of Recent Ongoing Inter-Communal Violence and Displacement, No. 2, 22 Oct. 2018, pp. 1-4.

121 Economic Intelligence Unit. 2018. Country Report Ethiopia, 2018, pp. 2, 4.

122 Ibid. See also The Economist, A Dilemma in the Horn of Africa: The promise and peril of Ethiopia's democratic revolution, Dec. 2018, available at: https://amp.economist.com/middle-east-and-africa/2018/12/08/the-promise-and-peril-of-ethiopia-democratic-revolution?__twitter_impression=true.

123 Disaster Risk Management Technical Working Group. 2018. Ethiopia: Humanitarian Response Situation Report, No. 19, Nov. 2018, p. 7.

124 United Nations High Commissioner for Refugees. Ethiopia: Renewed influx of Eritrean refugees, Oct. 2018.

125 Anecdotal information suggests that cumulative refugee flows in 2019 are far higher than what was reported in late 2018.

126 Ibid.

1.7.3. Disease outbreaks and epidemics

Communicable disease outbreaks, such as acute watery diarrhoea, measles and scabies (which may be the result of water scarcity and sub-optimal hygiene) are threats to children, especially for those who are malnourished. Since 2015, children in 290 woredas have been affected by acute watery diarrhoea, particularly in the Somali region.¹²⁷ Measles outbreaks have an even broader reach, with 165 high hotspot woredas and 505 vulnerable woredas, particularly in drought-affected areas.¹²⁸ As explored in Section 2.4, which focuses on health, there are major shortfalls in child vaccination coverage, a preventive measure against outbreaks of vaccine-preventable diseases such as measles. Similarly, as explored in Section 2.6 (WASH), low population coverage estimates for safely managed water and safely managed sanitation, in addition to major shortfalls in hygiene practices, suggest clear areas of priority to reduce the likelihood of certain disease outbreaks, such as acute watery diarrhoea.

Overcrowding and over-extended infrastructure (e.g., WASH infrastructure) in IDP and refugee host communities can fuel disease outbreaks.¹²⁹ As conveyed in the latest Humanitarian Response Plan, there is an awareness that the private sector needs to be better leveraged for issues such as WASH, education and reaching hard-to-reach or under-served population segments (e.g., out-of-school children) to foster better links between the humanitarian response and development programming.¹³⁰ However, as with other issues of national significance for which the private sector could make meaningful contributions (as a partner with government and conventional development partners such as bilateral donors



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and UN agencies) that envisioned role has not yet materialized.

1.7.4. Economic shocks

In Ethiopia, the risk and impact of economic shocks should not be considered in isolation of other phenomena (e.g., urbanization) occurring within the country. For example, a 2013 vulnerability study commissioned by the World Bank noted that: “As poverty becomes more urban, sudden food price increases also become more of a challenge.”¹³¹ Although rarely described as drivers of humanitarian need to the same extent as conflict and climate variability, both macro- and micro-economic shocks can spur emergencies.¹³² Inflation and increases in food prices add another layer of complexity to the issue of vulnerability. The Central Statistical Agency (CSA) has already documented food price inflation.¹³³ As mentioned previously, agriculture plays a prominent role in Ethiopia’s economy, accounting for 37 per cent of GDP and 73 per cent of the country’s labour force.¹³⁴

127 United Nations Office for the Coordination of Humanitarian Affairs. 2018. ‘Mapping of Recurrent Climate Shocks and Humanitarian Impact vs Development Programming’ (Draft).

128 UNICEF Health section, consultation 14 November 2018. See also UNICEF, Humanitarian Situation Report, Horn of Africa Measles Outbreak Response, May 2017.

129 National Disaster Risk Management Commission, Humanitarian Country Team and partners. 2019. Humanitarian Needs Overview.

130 United Nations. 2019. Humanitarian Response Plan 2019.

131 Vargas Hill, R. and Porter, C. 2013. Vulnerability Study to Assist with Assessment of Potential Caseload for Next Generation of PSNP & HABP.

132 National Disaster Risk Management Commission, Humanitarian Country Team and partners. 2019. Humanitarian Needs Overview.

133 Ibid.

134 United Nations Development Programme. 2018. Ethiopia National Human Development Report 2018: Industrialization with a human face, available from <https://bit.ly/2DTnnWG>.

At a micro-economic level, many Ethiopian households depend on fertile land and favourable weather conditions for agricultural and livestock production as a core aspect of their livelihoods.¹³⁵

1.7.5. Food insecurity—a frequent by-product of hazards in Ethiopia

As will be described in a later chapter on nutrition, malnutrition in both children and women is an issue of national significance. Ethiopia ranked 100th out of 113 countries on the Global Food Security Index 2018. This low ranking reflects the high degree of food insecurity in the country, which is not just contingent upon food sufficiency and dietary diversity, but also contextual factors such as political stability.¹³⁶ Acute food insecurity resulting from erratic rainfall performance and droughts are an annual occurrence in Ethiopia, and both their frequency and intensity is increasing.¹³⁷ The latest Humanitarian Response Plan (2019) notes that both public and private seed companies have reported an estimated 40,000 quintals of crop loss (e.g., hybrid maize and other crops), which is expected to negatively impact crop production in the forthcoming season.¹³⁸ Shortages in staple foods and challenges with nutrition and food assistance have been linked to undernourishment in children under 5, and both pregnant and lactating mothers in IDP camps, for example in Gedeo (SNNP) and East and West Hararghe (Oromia). There are projections of further deterioration of nutritional status through September 2019.¹³⁹ Focus group discussions with children and adolescents for a UNICEF-commissioned study in 2018 highlighted the domino effects and interplay between water availability, agriculture, food

Box 7.

VOICES OF CHILDREN AND ADOLESCENTS

“[During the drought] our consumption of milk was highly decreased, vegetable consumption totally stopped because irrigation was decreased, and the amount and frequency of food supply was decreased. We had hunger every day and things would have been difficult if the school feeding programme had not been in place.” (Tigray, Adishum Bereket kebele, focus group discussion (FGD) with younger children).

Taken from UNICEF Ethiopia-commissioned research: Oxford Policy Management and the Horn Economic and Social Policy Institute (2018) *Generation El Niño: Long-term impacts on children’s well-being: Final Report*. UNICEF: Ethiopia Country Office

security and other child-focused outcomes, such as school attendance (**Box 7**).

1.8. Resilience

Recurrent hazards test the bounds of resilience for households, communities and the nation as a whole. Examining the situation through the lens of child well-being, resilience can be defined as “the ability of children, communities and systems to withstand, adapt to and recover from stresses and shocks, advancing the rights of every child, with special attention to the most vulnerable and disadvantaged children.”¹⁴⁰

The Ministry of Finance commissioned a 2018 study carried out by the World Bank and the United Kingdom’s Department for International Development (DFID) to examine issues related to the resilience of lowland populations to external shocks.¹⁴¹ According to that study, lowland areas are much more vulnerable to poverty than other ecological zones in the country, with 66 per cent of populations in those areas either already poor

135 The World Bank. 2015. Ethiopia Poverty Assessment 2014, p. xix.

136 Global Food Security Index 2018, available at: <http://foodsecurityindex.eiu.com/Country>.

137 National Disaster Risk Management Commission, Humanitarian Country Team and partners. 2019. Humanitarian Needs Overview.

138 United Nations. 2019. Humanitarian Response Plan 2019

139 National Disaster Risk Management Commission, Humanitarian Country Team and partners. 2019. Humanitarian Needs Overview.

140 UNICEF Ethiopia Country Office. 2013. ‘Resilience Mid-term Review Discussion Paper’.

141 The World Bank Group and the UK Department for International Development. 2019. ‘Poverty and Vulnerability in the Ethiopian Lowlands: Building a More Resilient Future: Executive Summary’ (Draft).

or at risk of becoming poor in the event of a shock.¹⁴²

Enhanced resilience requires greater social and economic inclusion of vulnerable groups (e.g., pastoralists, agro-pastoralists, farmers).^{143,144} There is published evidence that agro-pastoral households and male-headed households are better able to withstand climate-induced shocks than pastoralist households and female-headed households.¹⁴⁵ Identified resilience 'enhancers' have included factors such as access to markets, access to credit, extension services and education, providing agricultural inputs and improving farm irrigation.¹⁴⁶ Selected sectors have undertaken tailored strategies to build resilience. For example, the Ministry of Water, Irrigation and Electricity developed a US\$ 5 billion programme in drought-prone areas, with a strong focus on climate-resilient WASH that is now incorporated into Ethiopia's One WASH National Programme. Integrating lowland areas into an inclusive growth path

for Ethiopia will require both political will and financial investment to implement services that are effective, scalable and fit-for-purpose in those contexts.



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142 Ibid.

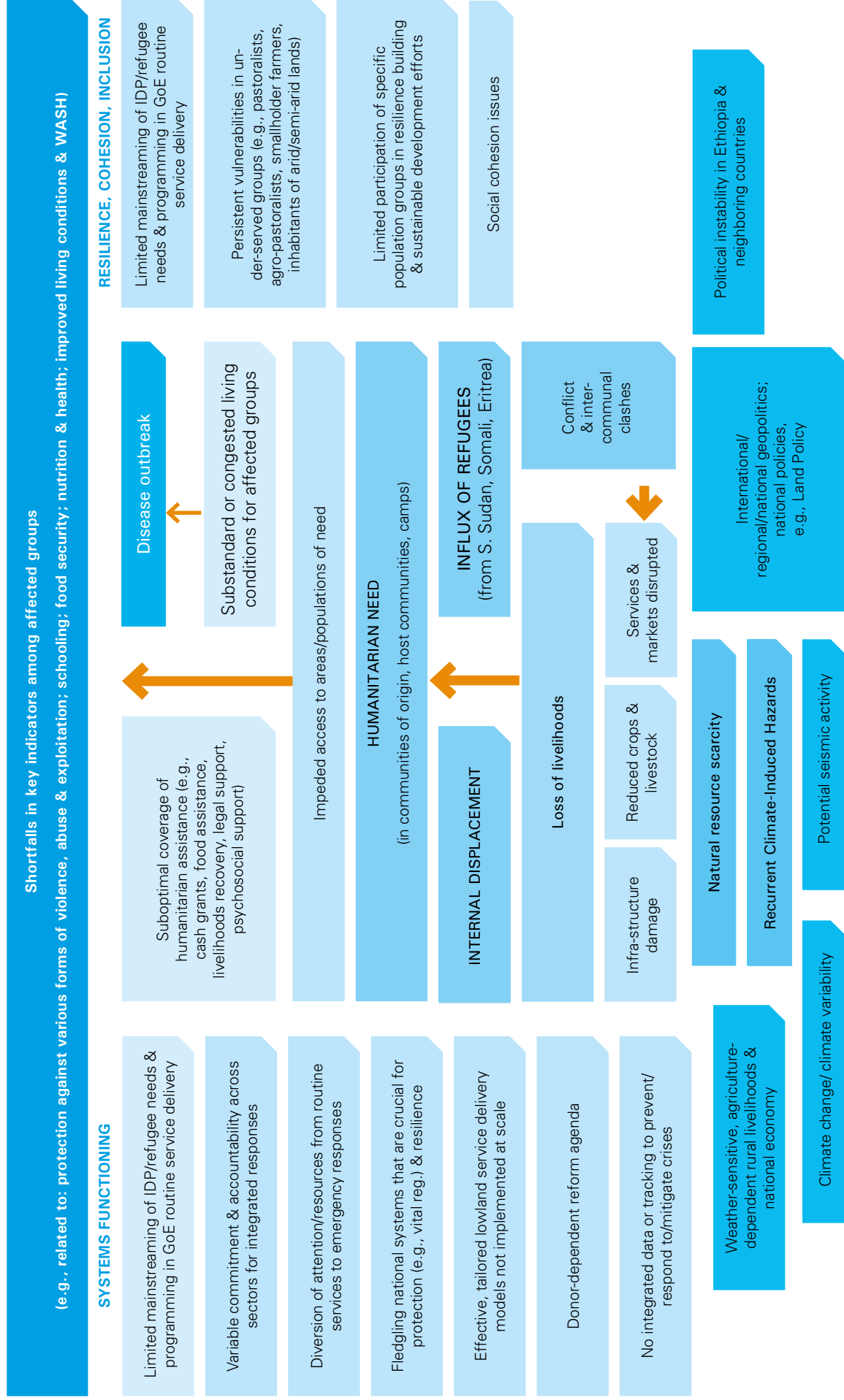
143 Birhanu, Z., Ambelu, A., Berhanu, N., Tesfaye, A. and Woldemichael, K. 2017. 'Understanding Resilience Dimensions and Adaptive Strategies to the Impact of Recurrent Droughts in Borana Zone, Oromia Region, Ethiopia: A grounded theory approach', *International Journal of Environmental Research and Public Health*, 14(2), 118. doi:10.3390/ijerph14020118.

144 United Nations Office for the Coordination of Humanitarian Affairs. HRD Relief Food Beneficiary Analysis (2013-2018).

145 Mekuyie, Muluken, Jordaan, Andries and Melka, Yoseph. 2018. 'Understanding Resilience of Pastoralists to Climate Change and Variability in the Southern Afar Region, Ethiopia', *Climate Risk Management*, 20. 10.1016/j.crm.2018.02.004.

146 Ibid.

Figure 6. Drivers and effects of the humanitarian situation affecting Ethiopia





2.

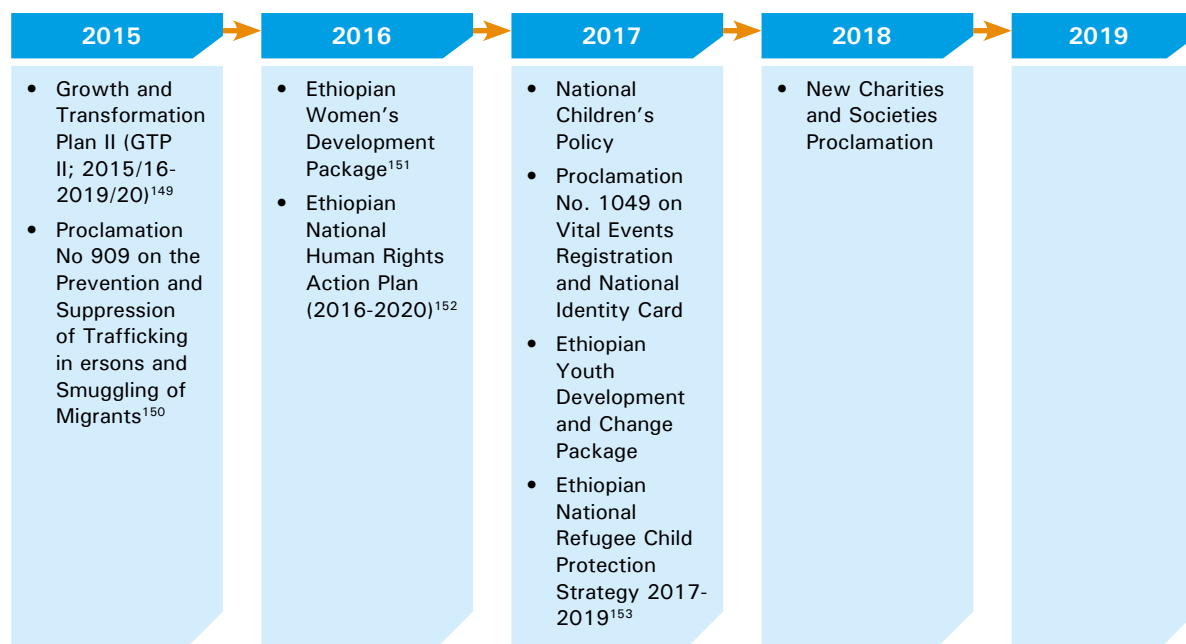
THE STATE OF ETHIOPIA'S CHILDREN AND WOMEN

2.1. Ethiopia's general progress on women's and children's rights

As stated previously, the CRC is a globally endorsed framework that mandates all countries to address the multiple aspects of child welfare and development.¹⁴⁷ Since 2015, there has been an expansion of Ethiopia's policy and legal landscape to safeguard the rights of both women and children. **Figure 7** highlights the major policies, plans and legislation that have emerged since 2015, when the last Situation Analysis of women and children in Ethiopia was conducted. Some of the policies and plans have an explicit focus on children (e.g., 2017 National Children's Policy) while others address broader human rights issues that also affect children (e.g., human trafficking, via Proclamation No. 909 of 2015).¹⁴⁸ The National Children's Policy, in particular, is a milestone achievement in establishing a robust national legislative framework for addressing and enforcing the CRC. In addition to the general policy developments highlighted below, various sectors have introduced sector-specific policies, strategies and plans that address different dimensions of child, adolescent and women's well-being.

147 Article 27 CRC. The Government of Ethiopia ratified the CRC in 1991.

148 Federal Negarit Gazette of the Federal Democratic Republic of Ethiopia. 21st Year No. 67. Addis Ababa, 17 August 2015.

Figure 7. Changes to the child- and woman-sensitive policy/legislative landscape since 2015

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The recent report on Ethiopia's fulfilment of obligations related to CEDAW acknowledges achievements in revising legal and policy frameworks to promote the human rights of women, as well as expanding the reach of health and education services.¹⁵⁴ However, the CEDAW Committee for Ethiopia also identified three key constraints in advancing gender equality:¹⁵⁵

Outstanding gaps in policy and legal frameworks (especially in relation to critical issues such as violence against women, inconsistency between federal and regional legislation and enforcement of harmful practices, such as child marriage and FGM, and the lack of regulatory frameworks for affirmative action).

A combination of factors, including new policies and legislation, has led to national achievements related to children (**Figure 8**).

1. Shortcomings related to institutional structures, particularly in the area of coordination and accountability.
2. Financing and resource allocation in all sectors for gender equality and women's empowerment.
3. The remaining chapters of this report examine how the existing policies, strategies and plans, as well as the

149 National Planning Commission. 2016. Growth and Transformation Plan II (GTP II) (2015/16-2019/20). Volume I: Main Text.

150 Federal Negarit Gazette of the Federal Democratic Republic of Ethiopia. 21st Year No. 67. Addis Ababa, 17 August 2015.

151 Developed by the Ministry of Women, Children and Youth.

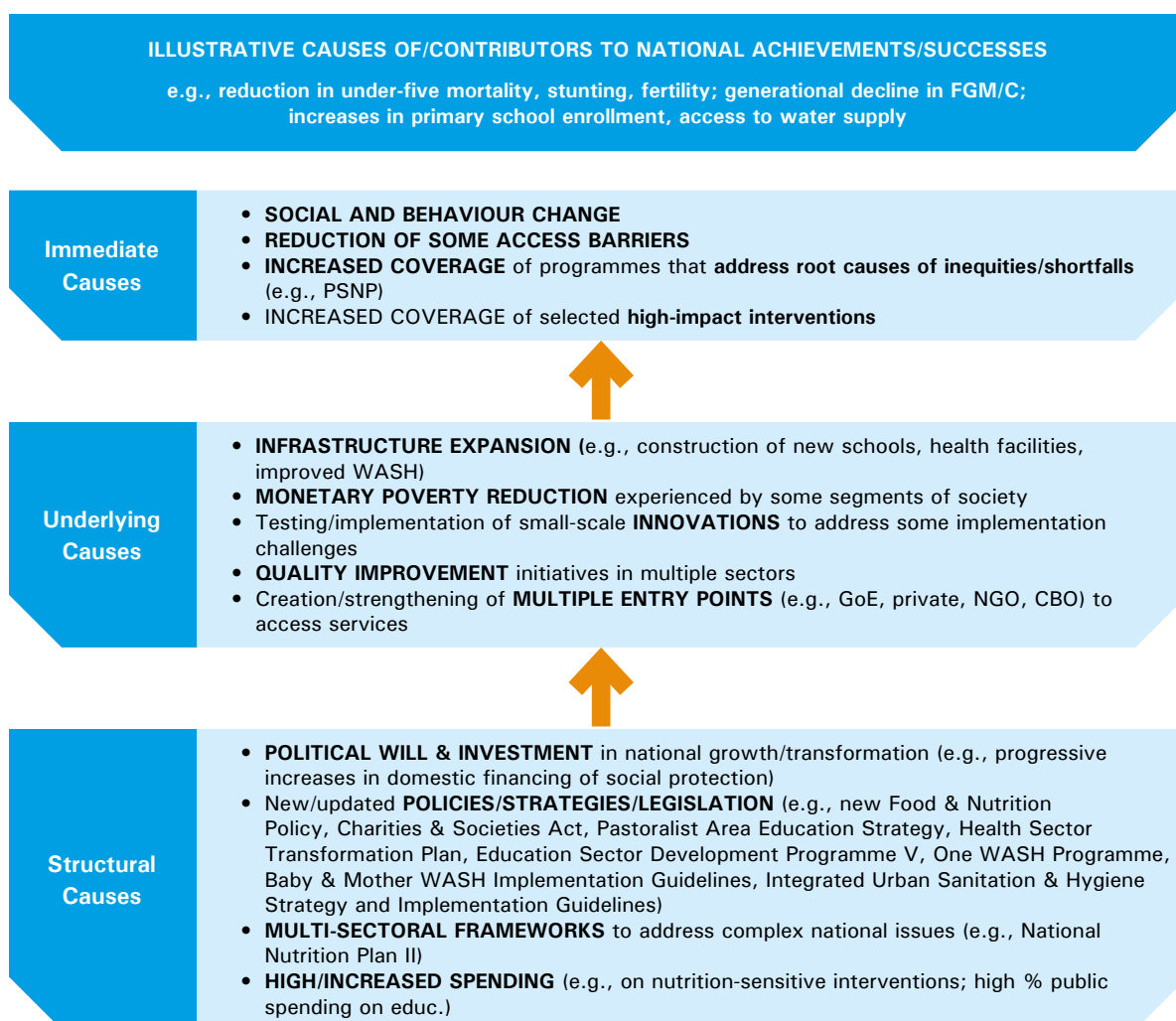
152 Office of the National Human Rights Action Plan, Federal Attorney General. 2016. The Ethiopian National Human Rights Action Plan, 2016-2020

153 United Nations High Commissioner for Refugees. 2017. Retrieved from <https://data2.unhcr.org/en/documents/download/62618>

154 United Nations Country Team. 2018. Report to the Convention on the Elimination of All Forms of Discrimination Against Women Committee (the Committee) for Ethiopia.

155 Ibid.

Figure 8. Key factors that have contributed to recent national achievements related to children and women



absence of critical policies and legislation, have impacted outcomes for women and children in various sectors.

Evidence also shows that when adversities in early childhood go unaddressed, they often have long-lasting negative consequences in adulthood, such as compromised health and reduced earning potential.¹⁵⁸

2.2. Early childhood development

In order for Ethiopia to achieve its growth and transformation goals, including transitioning to low-middle-income status, ECD must be addressed as a foundational element of national development.¹⁵⁶ There is compelling global evidence that both extremely poor children and children affected by humanitarian crises—two large categories of children in Ethiopia—are often exposed to multiple factors that can adversely affect their development.¹⁵⁷

The globally endorsed ‘Nurturing Care Framework for Early Childhood Development’ underscores the multi-faceted, multi-sectoral nature of ECD, which is a function of good health, adequate nutrition, security and safety (including WASH), opportunities for early learning and responsive caregiving.¹⁵⁹ Thus, multiple

156 Richter, L.M., Daelmans, B., Lombardi, J. et al. 2017. ‘Investing in the Foundation of Sustainable Development: Pathways to scale up for early childhood development’, *Lancet*, 389(10064):103–18.
157 Britto, P.R., Lye, S.J., Proulx, K. et al. 2017. ‘Nurturing Care: Promoting early childhood development’, *Lancet*, 389(10064):91–102.

158 Hoddinott, J., Maluccio, J.A., Behrman, J.R., Flores, R. and Martorell, R. 2008. ‘Effect of a Nutrition Intervention During Early Childhood on Economic Productivity in Guatemalan Adults’, *Lancet*, 371(9610):411–6.
159 World Health Organization, UNICEF, World Bank Group. 2018. *Nurturing Care for Early Childhood Development: A framework for helping children survive and thrive to transform health and human potential*. Geneva: World Health Organization. Licence: CC BY-NC-SA 3.0 IGO.

programmes and sectors bear responsibility for ECD outcomes within their remit.

2.2.1. Policy and stakeholder landscapes

In 2010, Ethiopia approved the national, multi-sectoral Early Childhood Care and Education (ECCE) Policy Framework, as well as an ECCE strategic operational plan and guidelines. Although the ECCE Policy has existed for almost a decade, bottlenecks related to coordination and full implementation of the policy persist. A memorandum of understanding has been signed by the Federal Ministries of Education, Health and Women's and Children's Affairs. Those sectors are currently updating the policy framework to address identified gaps and ensure alignment with global ECD standards, such as the Nurturing Care Framework. The country also signed onto various international conventions that are relevant to ECD, such as the CRC, the Convention on the Rights of People with Disabilities, and the CRC Sale of Children, Child Prostitution and Child Pornography.¹⁶⁰ In addition, some of Ethiopia's sectoral policies, plans and guidelines that have emerged in recent years, in education, health, nutrition and, to a lesser extent, WASH, contain ECD-sensitive/related components, even when ECD is not mentioned explicitly. For example, ESDP V emphasizes ECCE within the formal education sector.¹⁶¹ FMoE has developed and implemented non-formal accelerated child readiness and child-to-child programmes to complement 'O' classes (which are affiliated with primary schools) to increase access to pre-primary education.

In recent years, the health sector has been proactive with respect to ECD and, with a strategic document in place, has been mainstreaming elements of ECD, such as the promotion of positive parenting, into health work. There is a plethora of health policies, strategies, guidelines and plans that address the health and nutrition-related aspects of ECD. One such policy is the National Strategy

on Newborn and Child Survival, 2015/2016-2019/2020. The broader health sector roadmap, the Health Sector Transformation Plan (HSTP) 2015/2016-2019/2020, places great emphasis on supply-side and demand-side strategies to improve early child health and survival, although ECD is not referenced specifically in the plan.¹⁶² The FMoH has also developed an ECD situation analysis and a policy brief on ECD.

The launch of Ethiopia's Baby and Mother WASH Implementation Guidelines (with a successful pilot of Baby WASH) is a policy contribution to creating an enabling environment for ECD, highlighting the need for cross-programme collaboration between WASH, nutrition and maternal, newborn and child health. The recently revised WASH in Schools manual included a section dedicated to WASH facilities for pre-primary school children.

Ethiopia's policy landscape has expanded to better address the good health, adequate nutrition, and early learning aspects of ECD. However, there are clear ECD-related policy gaps in relation to responsive caregiving and security and safety dimensions, for example violence against children, the issue of paid maternity and paternity leave, a national minimum wage, and child-sensitive social protection.

As mentioned, the education and health sectors are prominent players in the current ECD landscape, with the WASH sector also working in conjunction with those two sectors on pilot programmes (with a successful pilot of Baby WASH). Development partners are working in tandem with various government and non-government entities to implement activities, however many of those efforts are being pursued on a pilot basis and are limited to a small number of regions, with little coordination. Particularly within the education arena, private organizations, NGOs and CSOs have emerged as important actors in early childhood education.

However, there is no cross-sectoral entity or platform at federal or sub-national level to coordinate efforts or synthesize

160 Early Childhood Development Country Profile: Ethiopia. n.d. Retrieved from <https://nurturing-care.org/wp-content/uploads/2018/10/Ethiopia.pdf>

161 Federal Ministry of Education. 2015. Education Sector Development Programme V (ESDP V) 2008–2012 E.C. 2015/16–2019/20 G.C: Programme Action Plan.

162 Federal Ministry of Health/Federal Democratic Republic of Ethiopia. 2015. Health Sector Transformation Plan 2015/16-2019/20 (2008-2012 EFY).

evidence across multiple actors and sectors, or to provide oversight for the roll out and replication/scale up of high-impact interventions related to ECD. It is difficult to track financing or expenditure related ECD and, as noted below, there are gaps in relation to current ECD-sensitive/related efforts.

2.2.2. Levels, trends and differentials in key indicators

Table 4 presents trend data on selected indicators, mapped according to the five key ECD dimensions (good health, adequate nutrition, security and safety, opportunities for

Table 4. Trends in point estimates of selected ECD-related indicators based on EDHS and EMDHS data

INDICATOR	EDHS ESTIMATES (%)			2019 EMDHS ESTIMATE
	2005	2011	2016	
GOOD HEALTH				
Pre-conception				
Modern contraceptive use among currently married women aged 15-49 years	13.9	27.3	35.3	40.5 ^(a)
Conception to birth				
At least four antenatal care visits (ANC 4)	12.2	19.1	31.8	43
After delivery/child health				
Postnatal check for the newborn in first two days after birth	NA	NA	13.1	33.8 ^(b)
Percentage of children aged 12-23 months who received all basic vaccinations ^(c)	20.4	24.3	38.5	43.1
ADEQUATE NUTRITION				
Exclusive breastfeeding rate among 0- to 5-month-olds	49	52	57.5	58.8
Minimum acceptable diet among 6- to 23-month-olds	NA	4.1	7.3	NA
Stunting (Height for age < -2 standard deviations [SD]) among children aged 0-59 months	46.5	44.4	38.4	36.8
Wasting (Weight for height < -2SD) among children aged 0-59 months	10.5	9.7	9.9	7.2
SECURITY & SAFETY				
Birth registration rate	6.6	NA	2.7	NA
Population access to improved drinking water source	60	50.8	61.6	NA
Population access to improved sanitation facility	7.4	8.8	6.7	NA
Percentage of children exposed to inadequate care	NA	NA	NA	NA
Percentage of children exposed to harsh discipline	NA	NA	NA	NA
OPPORTUNITIES FOR EARLY LEARNING				
Gross enrolment rate for pre-primary education ^(d)	34	–	44	NA
No EDHS data available for other relevant outcomes				
RESPONSIVE CAREGIVING				
No data available				

NA: Not available.

^(a)Only available for currently married women aged 15-49 years.

^(b)Among women who had a live birth in the two years preceding the survey, the percentage with a postnatal check during the first two days after birth.

^(c)As per the 2016 EDHS and 2019 EMDHS, all basic vaccinations include: one dose of BCG vaccine, three doses of DPT-HepB-Hib, three doses of polio vaccine and one dose of measles vaccine.

^(d)Data obtained from the FMoE. 2018. Education Statistics Abstract, Ethiopian Calendar (E.C.) 2010 (2017/2018). Data presented do not pertain to the same years as the EDHS. The two estimates for pre-primary gross enrolment rate pertain to 2013/2014 and 2017/2018.

Data sources for all other indicators in the table: Ethiopian Public Health Institute and ICF. 2019. EMDHS; CSA and ICF. 2016. EDHS 2016; CSA and ICF International. 2012. EDHS 2011; CSA and ORC Macro. 2006. EDHS 2005.

early learning and responsive caregiving). With the exception of education data, the EDHS serves as the primary source of data on ECD dimensions. As shown in the table, there are shortfalls with respect to all ECD dimensions, with multiple rounds of EDHS and the latest EMDHS indicating only modest improvements in most indicators. Also noteworthy is the absence of available data on responsive caregiving and early learning.

ECD indicators such as the ECD Index (ECDI) (the percentage of children aged 36-59 months who are developmentally on track in literacy-numeracy, physical, social-emotional, and learning domains) are not available to track overall ECD status or progress. The ECDI is a population-level indicator that is usually included in Multiple Indicator Cluster Surveys (MICS) and is being used as a source of ECD comparison both within and across countries.¹⁶³ However, MICS have not been conducted in Ethiopia, and the ECDI has not yet been included in the EDHS. Moreover, child protection data among young children, for example, the percentage of young children exposed to inadequate care or harsh discipline, and data on caregiving practices among parents and caregivers are also limited.

2.2.3. Sector-specific recommendations

1. As highlighted in the Nurturing Care Framework, ECD is impacted before childbirth.¹⁶⁴ In advancing ECD efforts, map existing services, strengths, barriers and bottlenecks through a life-cycle lens, starting with pre-conception (e.g., child spacing, social protection) against the multiple deprivations observed among young children.
2. In lieu of a MICS, include questions in the next round of EDHS to enable an ECDI calculation.
3. Accelerate the process agreed by key line ministries (FMoH, FMoE, etc.) to: (a) develop an overall ECD and Education

Policy Framework (which will serve as an updated policy framework replacing the 2010 ECCE Policy Framework); and (b) prepare sectoral strategies and costed operational plans for implementation.

4. Strengthen the cross-sectoral platform at the federal level and establish cross-sectoral platforms/mechanisms at sub-national levels to elevate the prominence of ECD within the broader context of the country's implementation of GTP II (and the forthcoming GTP III). The aforementioned platforms/mechanisms should facilitate cross-sectoral planning, implementation and monitoring of ECD interventions.
5. In the short term, given the lack of data and action related to responsive caring and security and safety, (a) identify opportunities to address those domains during contact with children, caregivers and households in the health sector (e.g., health education efforts of health extension workers, counselling provided to mothers/caregivers during visits to health facilities); and (b) map and strengthen other possible ECD entry points (e.g., home-based and community-based parenting and child care) that can fall within the remit of child protection or social welfare actors. Existing health, nutrition and/or WASH community networks, as well as other networks or platforms with a capacity to reach families, can serve as ECD entry points.
6. Design ECD demonstration projects in target regions and woredas to test geographical convergence of ECD-sensitive interventions/services being implemented by different sectors under a shared result structure, with clearly defined indicators to: (a) demonstrate enhanced effectiveness of integrated ECD interventions; and (b) leverage greater investment from government and development partners for scale up.

2.3. Education

According to the CRC, all children are entitled to education (CRC Article 28); the goals of education are to develop a child's personality, talents and abilities to the fullest (CRC Article 29); and children are entitled to access to information and mass media (CRC Article 17).

¹⁶³ UNICEF. n.d. ECD Indicators: Multiple Indicator Cluster Surveys Fourth Round (MICS4), Retrieved from: https://www.unicef.org/earlychildhood/files/Website_data_presentation_Global_-_11_July_2013.pdf

¹⁶⁴ Ibid.

2.3.1. Policy and stakeholder landscapes

Ethiopia's formal education system is now organized according to the primary cycle (Grades 1-6), lower secondary (Grades 7-8) and high school (Grades 9-12).

Three SDGs reflect global standards related to education:

- **SDG 4.1**, which calls for ensuring that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes by 2030.
- **SDG 4.5**, which aims to eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable, including persons with disabilities, indigenous peoples and children in vulnerable situations by 2030.
- **SDG 4.7**, which aims to ensure that all learners acquire knowledge and skills needed to promote sustainable development (including through education and other means) for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and non-violence, global citizenship, and appreciation of cultural diversity and of culture's contribution to sustainable development by 2030.

The ESDP V, which is the overarching strategic plan that currently guides all activities within

the formal education sector, outlines priorities and strategies that are consistent with these SDGs. As shown in **Figure 9**, there are also special strategies and frameworks focusing on key sub-populations (e.g., pastoralists) or levels of education (e.g., ECCE). The Education and Training Roadmap, which is currently being finalized and will be the guiding policy framework until 2030, is proposing substantial reforms in education.

The government is the main provider of education services in most parts of the country. However, as shown in Figure 9, non-governmental entities are playing prominent roles in relation to kindergarten education, as well as secondary education in urban centres such as Addis Ababa, Harari and Dire Dawa.¹⁶⁵ In the last academic year, the number of non-governmental secondary schools (150, 9 and 12 in Addis Ababa, Harari and Dire Dawa, respectively) exceeded the number of government-run secondary schools (72, 7 and 11 in Addis Ababa, Harari and Dire Dawa, respectively).¹⁶⁶

There has been a rapid expansion of early childhood education (ECE) services, with gross enrolment increasing substantially between 2011/12 (21.6 per cent) and 2017/18 (44.2 per cent), according to FMoE data. Nonetheless, there remain considerable regional inequities. For example, only 4.5 per cent of young children in Somali access ECE services, compared with 86.8 per cent of their peers in Tigray. In recent years, FMoE has significantly increased its investment in ECE as a means of tackling the issue of primary school dropouts and improving student learning outcomes by Grade 4. As part of the ECE policy framework, the FMoE strategy is to deliver a combination of short term, less formal ECE interventions alongside the expansion of a pre-primary class across all primary schools. Currently, the pre-primary year ('O-class') introduced in 2010, contributes the largest enrolment share within ECE, with a gross enrolment ratio of 70.1 per cent in 2017/18, according to FMoE. In 2017, FMoE mandated all regions with introducing an accelerated school readiness programme

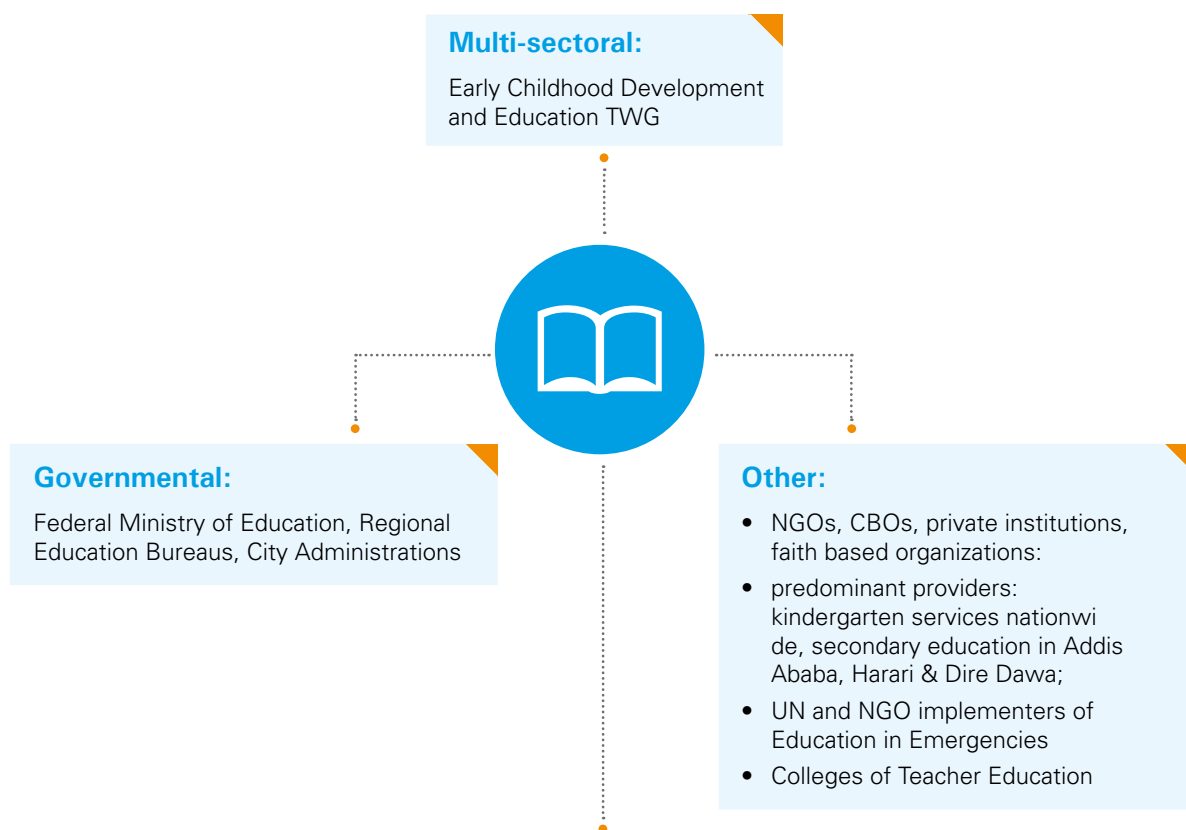


¹⁶⁵ Federal Ministry of Education. 2018. Education Statistics Annual Abstract 2010 E.C. (2017/18).

¹⁶⁶ Ibid. p. 67

Figure 9. Stakeholder and policy landscape for education

KEY ENTITIES AND STRUCTURES IN THE CURRENT EDUCATION LANDSCAPE



THE CURRENT POLICY AND LEGAL LANDSCAPE RELATED TO EDUCATION

For the General Population: Fifth Education Sector Development Program (ESDP V)

Specifically related to Children: National Early Child Care and Education (ECCE) Policy Framework

- National ECCE Guidelines
- National Strategy for Non-formal Accelerated Child Readiness
- Pastoralist Area Education Strategy (2009)
- National Alternative Basic Education Strategy (2006); General Education Quality Improvement Programme for Equity (GEQIP-E)

as an intermediate means of fast tracking ECE enrolment targets in more remote parts of the country. However, the rapid expansion of ECE services with limited financial resources has come at the expense of quality. Classes are poorly equipped, there is a lack of standardized pedagogical strategies/curricula, and there are insufficient numbers of trained teachers. The absence of minimum service standards for ECE sites further hinders the ability to enforce quality.

Humanitarian crises have disrupted education in many parts of the country, however deliberate efforts have been made to ensure that the majority of affected children have access to

primary education.¹⁶⁷ According to the 2019 Humanitarian Response Plan, there remain challenges in linking emergency-affected children with educational services, due in part to population movement, damaged school infrastructure, limited temporary learning spaces, lack of learning materials, and inadequate food and water in schools.¹⁶⁸ School closure is still a major issue in Somali (244 closed schools), as well as in Oromia (84), Benishangul Gumuz (41) SNNP (32), Afar (9) and Gambella (4).¹⁶⁹

¹⁶⁷ National Disaster Risk Management Commission, Humanitarian Country Team and partners. 2019. Humanitarian Needs Overview.

¹⁶⁸ United Nations. 2019. Humanitarian Response Plan 2019.

¹⁶⁹ Ibid.

Alternative models have been introduced in some regions, with donors and development partner support. Alternative basic education exists as a means of providing education services for hard-to-reach children in pastoral and remote rural areas of the country.

Some Regional Education Bureaus are employing creative solutions to meet the educational needs of some humanitarian-affected children. For example, the Tigray Regional Education Bureau has started to donate supplies to support a live TV mode of instructional delivery in Mai-Aini Secondary School, as part of a broader effort to align the delivery of educational services in refugee camps with the national system.¹⁷⁰

Despite such strides, there remains an unfinished agenda in ensuring that all historically marginalized groups of children are not left behind. For example, the Household Consumption and Expenditure Survey 2015/2016 showed that 43 per cent of school-aged children with disabilities had never attended school, almost twice the national average for all school-aged children (22 per cent).¹⁷¹ The education sector's Master Plan for Special Needs and Inclusive Education (2016) is a recent development that better positions the FMoE and its partners to improve educational inclusion for children with disabilities.

2.3.2. Levels, trends and differentials in key indicators

Enrolment rates have generally risen for all levels of education, although current estimates for all levels are below ESDP V targets (Annex 1). Notably, Ethiopia does not have an education law, and hence there is no compulsory education. Progression through the system as a child ages is a challenge for both males and females, although school attendance rates have increased at all levels, with a narrowing gender gap.¹⁷² According to

Education Management Information System data for the 2017/2018 (Ethiopian Calendar (E.C.) 2010) school year, girls have a higher dropout rate for Grades 1-8 (11.4 per cent) than boys (10.9 per cent).¹⁷³ Net enrolment ratios for Grades 9-10 highlight the challenge in retaining children in school after primary level. Recent Education Management Information System data show that the national figure is only 24 per cent for females and males. Across primary and secondary levels, Somali and Afar fare consistently worse than the other regions.

Multiple regions have primary school net enrolment ratios above 100 per cent, signifying one or more of the following: (1) data-quality issues (e.g., the need for updated data on population size, which are used to estimate denominators for enrolment rates); (2) inaccurate age reporting of students when they enter school; and/or (3) children on the move who were not captured in regional population size estimates (e.g., children migrating into regions and attending schools).¹⁷⁴ The gross enrolment rate can be greater than 100 per cent when there are a large number of over-age (or under-age) students, as it measures the number of students regardless of age as a percentage of the official school-age population. Theoretically, the net enrolment rate cannot exceed 100 per cent. Values greater than 100 per cent can occur when: (1) the reference date for entry to school does not coincide with the birth dates of all the cohort eligible to enrol, (2) significant portions of the population start primary education earlier than the prescribed age and consequently finish earlier, or (3) there are inconsistencies in the enrolment and/or population data.

Addressing educational exclusion is an important component of achieving quality education for all. 0 shows that out-of-school children account for 14 per cent of all primary school aged children in the country. However, this share ranges from a low of 1.1 per cent in Addis Ababa to a high of 59.6 per cent in Afar.¹⁷⁵

Data on grade completion and National Learning Assessment scores shed light on shortcomings related to educational quality.

170 United Nations High Commissioner for Refugees. 2019. Bi-weekly Operational Update: 1-15 April 2019. Available at: <https://reliefweb.int/sites/reliefweb.int/files/resources/69023.pdf>. Accessed on May 8, 2019.

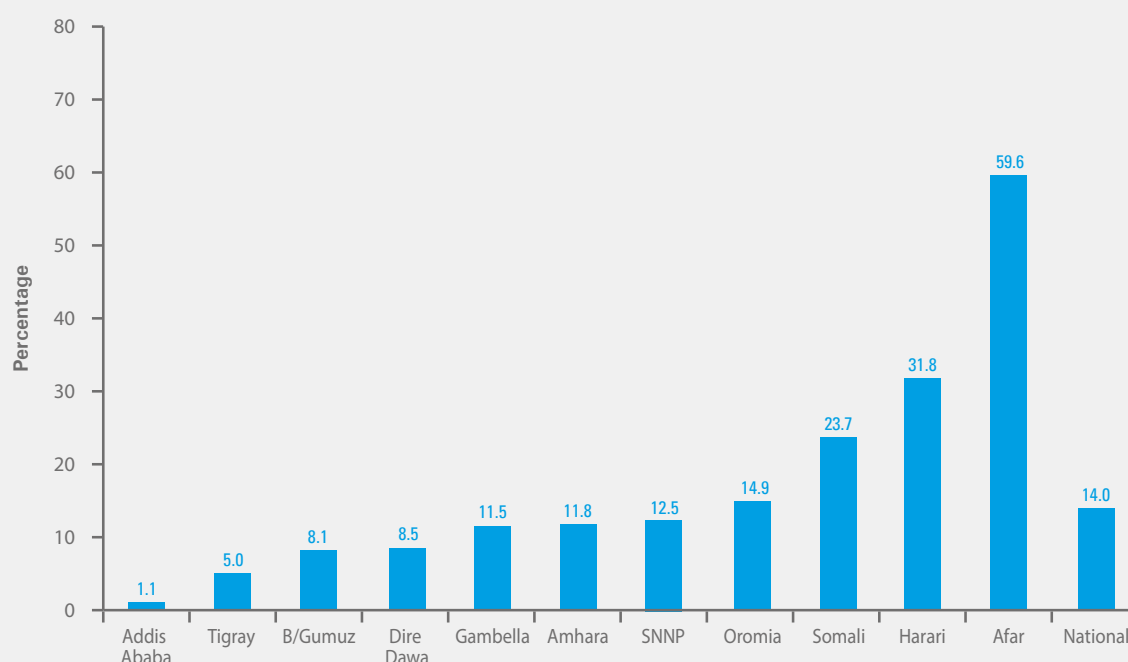
171 Central Statistical Agency/Federal Democratic Republic of Ethiopia. 2018. Household Consumption and Expenditure Survey 2015/16.

172 SPRI Global. 2019. Trends of Change in Gender Equality in Ethiopia (Policy Brief).

173 Federal Ministry of Education. 2018. Education Statistics Abstract 2010 E.C. (2017/18).

174 Ibid.

175 Ibid.

Figure 10. Out-of-School Children of Primary School

Source: UNICEF's calculations based on Education Statistics Annual Abstract, Education Management Information System, Ministry of Education, 2017-2018.



© UNICEF Ethiopia/2018/Mulugeta Ayene

As shown in **Figure 11**, completion rates for Grades 5 and 8 show an upward trend since E.C. 2002 (2009/10), although boys have consistently had higher completion rates than girls. In E.C. 2010, Grade 5 completion rates for boys and girls were 91.6 per cent and 84.3 per cent, respectively; corresponding Grade 8 completion rates were 59.5 per cent and 55.9 per cent, respectively (Annex 1).¹⁷⁶

¹⁷⁶ Ibid.

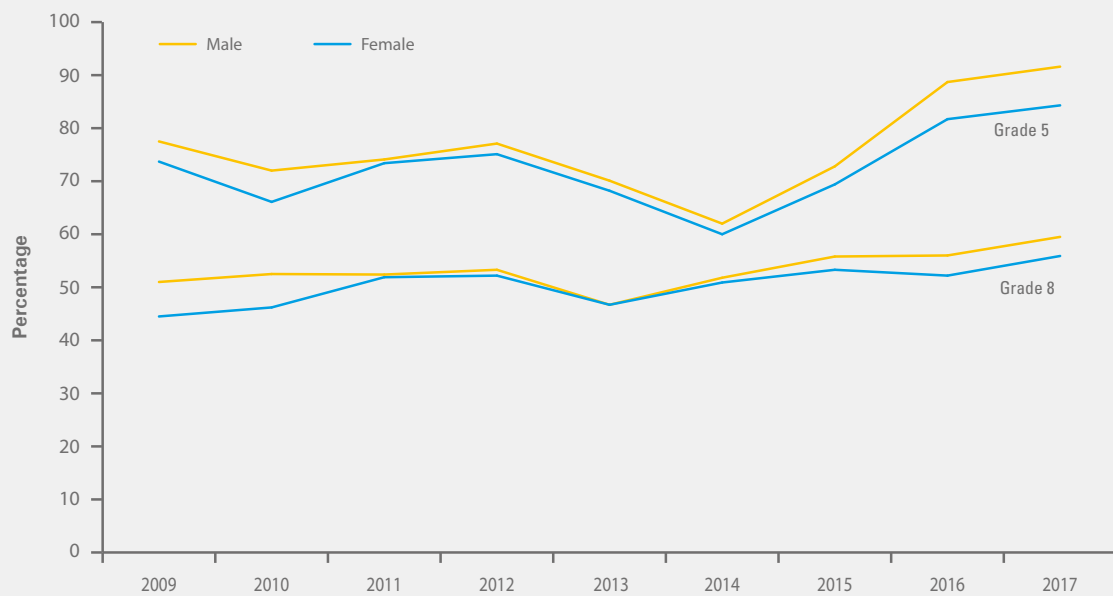
Average scores for the National Learning Assessment for Grade 4 and Grade 8 are only 44.7 per cent and 42.1 per cent, respectively (**Figure 12**), underscoring shortcomings related to educational performance among learners.

2.3.3. Drivers of identified shortfalls and differentials

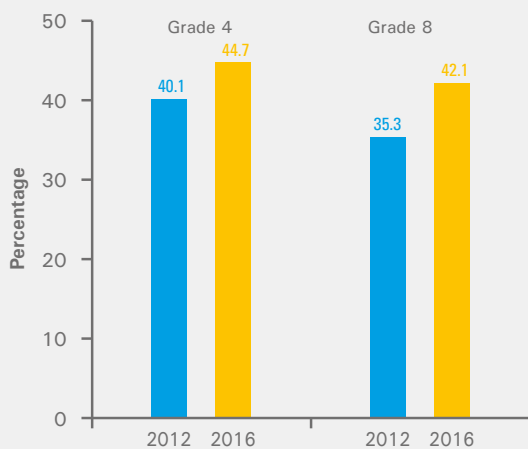
As displayed in detail in **Figure 13**, a multitude of factors contribute to observed shortfalls and differentials in education. These range from structural (social and gender norms that impact the likelihood of males versus females progressing through the education system; how budgetary resources are allocated within the education system) to more immediate or direct (the quality of education service delivery).

Both demand-side and supply-side underlying factors impact children's access to education and the quality of their educational experience.

For example, school availability is still an important driver of educational attainment in Ethiopia. There has been an expansion of physical infrastructure in the education sector:

Figure 11. Trends in completion rate of Grade 5 and Grade 8

Source: Education Statistics Annual Abstract, Education Management Information System, Ministry of Education, 2017-2018.

Figure 12. Students passing National Learning Assessment Grade 4 and Grade 8

Note: Proportion of children scoring 50% of higher (passing grade composite score).

Source: 'Fifth Ethiopian National Learning Assessment of Grades 4 and 8 Students', National Assessment and Examination Agency, 2016.

there were 36,466 primary schools in 2010 E.C. (2017/2018), up from 35,838 reported in 2009.¹⁷⁷ However, there are far fewer secondary schools than primary schools across the nation: 3,597 secondary schools, with 40 per cent based in Oromia region. There was only a 6 per cent increase in the number of secondary schools over the past two years,

¹⁷⁷ Ibid.

with most new secondary schools being opened in Somali and Tigray regions.¹⁷⁸

As an underlying factor, multi-dimensional child poverty is also part of the education causal pathway. Various forms of child poverty, such as hunger, can negatively impact a child's experience within the education system, and ultimately school performance (Box 8). Given the relationship between school performance and the ability to progress to higher levels of education, child poverty needs to be considered when improving child and adolescent education outcomes and education sector performance, in general.

Gender and social norms continue to be important structural factors (Figure 13). As described in the earlier section on gender equality, Ethiopia has not fully addressed gender inequality, ranking 121st out of 160 countries on the UN Gender Inequality Index in 2017.¹⁷⁹ Limited secondary school availability and the persistence of harmful practices such as child marriage, limit the likelihood of girls making the transition from primary to secondary school. Norms also impact the educational attainment of boys, some of whom

¹⁷⁸ Ibid.

¹⁷⁹ United Nations Development Programme. 2019. Table 5: Gender Inequality Index. Retrieved from: <http://hdr.undp.org/en/composite/GII>, 30 May 2019.

Box 8.

VOICES OF CHILDREN AND ADOLESCENTS

'I was coming to school without having my breakfast. Though I came to school like others, I was not interested to attend to what our teacher said...I was at school one morning without having my breakfast. I was hungry and felt weak. I sat in the compound alone waiting for the bell to ring. But I felt terrible when I saw others running and playing in the field. I silently cried for few minutes. I hate the area, the kids playing in front of me, and myself. I slowly walked to my home.' (Amhara, Sivilkay kebele, FGD with older girls).

Taken from UNICEF Ethiopia-commissioned research: Oxford Policy Management and the Horn Economic and Social Policy Institute (2018), *Generation El Niño: Long-term impacts on children's well-being: Final Report*.

UNICEF: Ethiopia Country Office

are diverted away from the education system to pursue income-generating work.

Measures are being taken to address quality within the education sector, and FMoE has formulated Phase 3 of its General Education Quality Improvement Programme, which focuses on improving the quality, internal efficiency and equity of the education system.

The availability of essential commodities is a significant limitation in the education sector. According to the E.C. 2010 Education Statistics Annual Abstract, students across Ethiopia have very limited access to learning materials. On average, they only have access to four textbooks each. This statistical abstract describes some of the other challenges within the education sector, such as ensuring that learning materials and curricula are responsive to the different languages spoken by the student population.

Teacher qualification is a key area of focus under ESDP V. A formal qualification programme for pre-primary teachers now exists within the colleges of teacher education, and standards for ECCE learning materials and the curricula are under development. However, outside of primary teacher training, there is a lack of data on progress related to teacher qualification. As reported in the 2010 E.C. Education Statistics Annual Abstract, 83

per cent of female teachers and 76 per cent of male teachers for Grades 1-4 are appropriately qualified.

Pupil-teacher ratios provide insight into educational quality. Ethiopia's pupil-teacher ratio standard is 50 pupils per teacher at primary level and 40 pupils per teacher at secondary level. According to the Annual Abstract, the national primary school pupil-teacher ratio in 2010 E.C. was 43 (55 for the first cycle and 35 for the second cycle). All regions except Oromia and Somali achieved the national standard of 50 pupils per teacher.¹⁸⁰

Gender balance within the education workforce is an issue that warrants further attention. According to the Annual Abstract, female teachers account for 89 per cent of all kindergarten teachers, but only 39 per cent of all primary school teachers and 19 per cent of all secondary school teachers.¹⁸¹ Only 9.2 per cent of primary school principals are female.¹⁸² The extent to which the gender composition has any bearing on the promotion of girls' education has not been studied.

2.3.4. Sector-specific recommendations

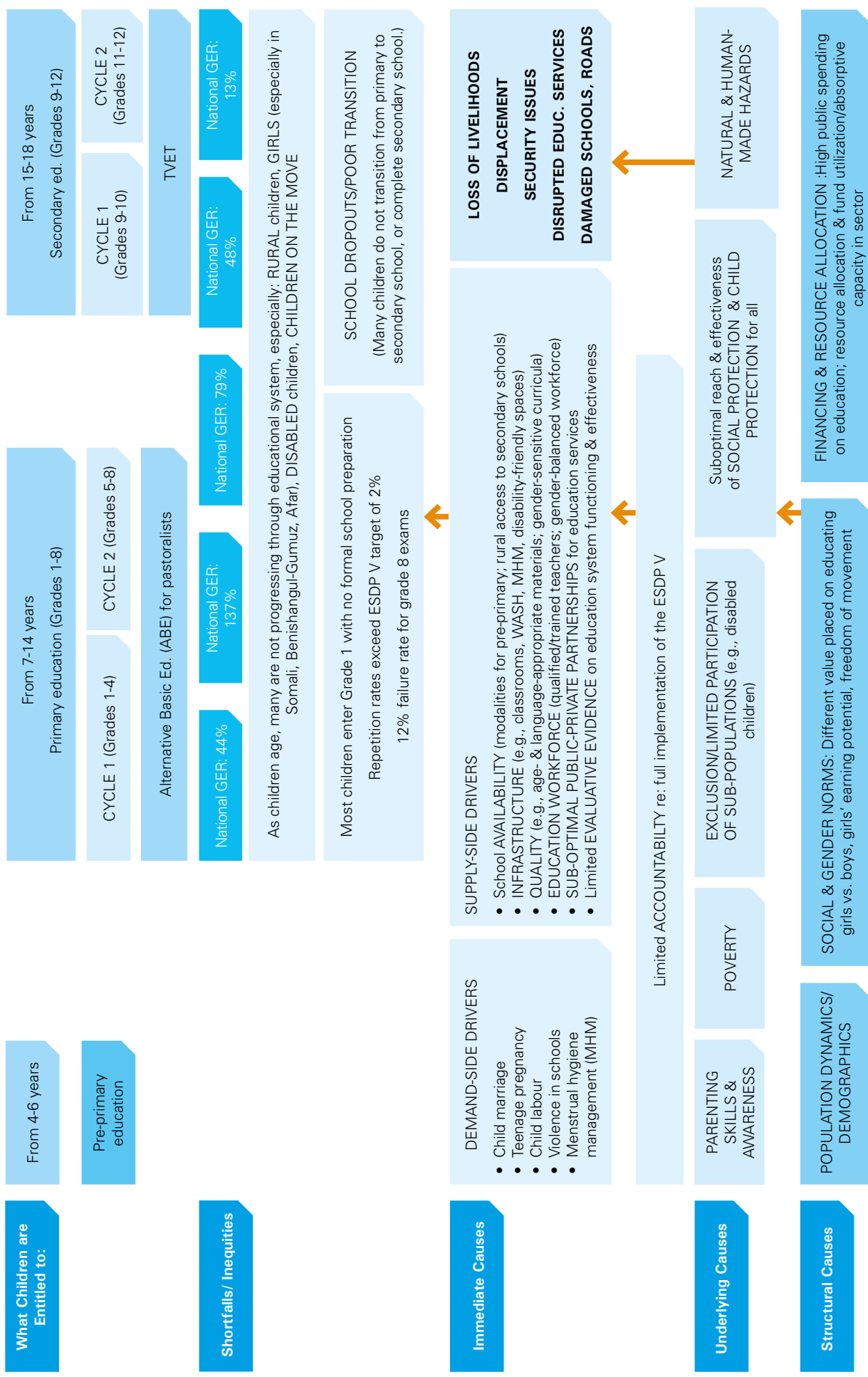
1. Prioritize greater harmonization, alignment and gender sensitivity in the content and quality of pre-primary, primary and secondary education across providers and locations.
2. In support of adolescent development and participation (described in a subsequent chapter on adolescents), test innovative models such as mobile-technology-based modalities for delivering standardized education content to adolescents who face physical and/or other access barriers to both primary and secondary education.
3. As a complement to the annual statistical abstracts produced by FMoE, conduct a sector-wide performance evaluation to document the effectiveness of current efforts in the sector vis-à-vis educational outcomes in different sub-sets of children

¹⁸⁰ Federal Ministry of Education. 2018. *Education Statistics Abstract 2010 E.C. (2017/18)*, p. 41.

¹⁸¹ Ibid. Table 1.6

¹⁸² Ibid. p. 97.

Figure 13. Causal pathways for shortfalls and inequities related to education



- (e.g., displaced children, rural children, adolescent girls, pastoralist children).
4. In light of the lagging performance in Afar and Somali, test and cost the scalability of the innovative models of education service delivery being implemented in those regions.
 5. As a precursor to advocacy for particular types of interventions within the education sector, conduct cost/value-for-money analyses to justify resource allocation decisions, including but not limited to sector allocations to primary versus secondary education, and the use of budgetary resources to address shortcomings related to the availability and quality of essential commodities, equipment and supplies within the sector.
 6. Devise and implement strategies that address demand-side barriers to educational inclusion and performance, for example social and gender norms. In light of common root causes in other sectors, for example child protection and health, explore comprehensive social and behaviour change strategies that entail cooperation/co-implementation with different sectors, not just education stakeholders.

2.4. Health

According to the CRC, all children are entitled to specific rights related to Survival and Development (CRC Article 6); Health and Health Services (CRC Article 24); Leisure, Play and Culture (CRC Article 31); and Access to Information/Mass Media (CRC Article 17).

2.4.1. Policy and stakeholder landscapes

Ethiopia's current sector-wide policy document, the HSTP 2015/2016-2019/2020, attempts to elevate the issue of equity through a series of strategies and a set of HSTP indicators to track progress toward equity transformation in the health sector.¹⁸³ HSTP is supported by other health-sector policies and strategies (**Figure 14**). As shown in the figure, there are many

183 Federal Ministry of Health/Federal Democratic Republic of Ethiopia. 2015. Health Sector Transformation Plan 2015/16-2019/20 (2008-2012 EFY).



© UNICEF Ethiopia/2018/Nahom Tesfaye

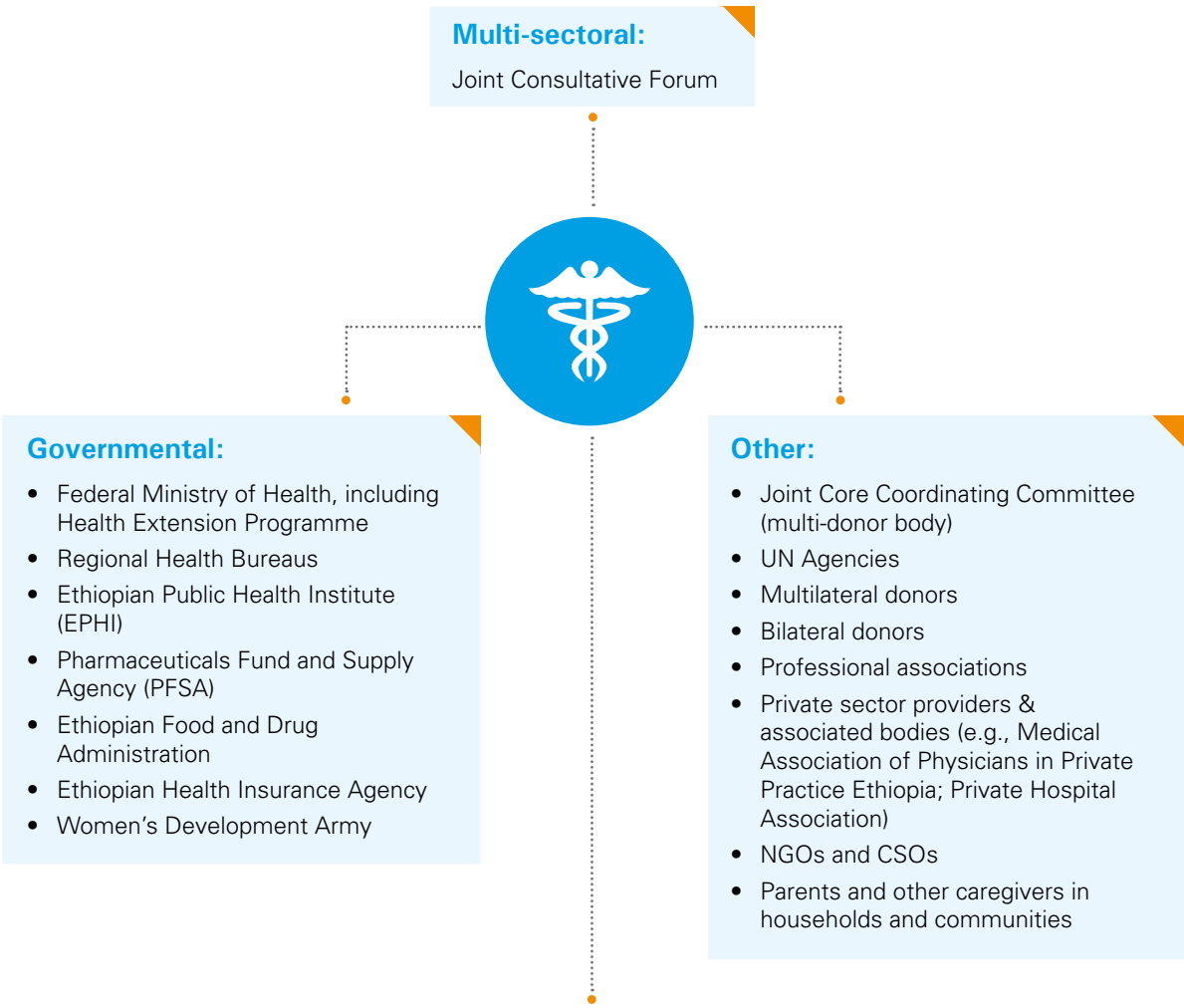
actors in the health arena: public, private, NGO/CSO, bilateral, multilateral (e.g., UN agencies), household and community level. There are also coordination mechanisms for the Joint Core Coordinating Committee and the Joint Consultative Forum.

As shown in **Figure 14**, there are distinct entities addressing specific aspects of the health system, including demand-side issues (e.g., Ethiopian Health Insurance Agency) and supply-side issues (e.g., Pharmaceutical Fund and Supply Agency). Private health care providers are also playing a more prominent role in health service delivery, particularly in urban settings. They are being utilized for specific types of services, for example the 2016 EDHS documented the following care-seeking pattern related to family planning:

- 41 per cent of oral contraceptive pill users obtained their supply from a private clinic or private pharmacy; in contrast, there is still a reliance on the public sector for other types of family planning (the public sector is the reported source for at least 82 per cent of women using other forms of family planning).
- 22 per cent of women in Addis Ababa and 14 per cent of women with more than a secondary school education deliver in private health facilities (far higher than the national average of 1 per cent).

Figure 14. Stakeholder and policy landscape for health

KEY ENTITIES AND STRUCTURES IN THE CURRENT HEALTH LANDSCAPE



THE CURRENT POLICY AND LEGAL LANDSCAPE RELATED TO HEALTH

Health Sector Transformation Plan (HSTP), 2015/16-2019/20

- Ethiopian National Health Care Quality Strategy 2016-2020
- National Health Promotion and Communication Strategy, 2016-2020
- National Health Equity Strategy
- Equitable Health Services Plan of Action, 2016–2020
- 2015-2020 Health Sector Regulatory Transformation Plan (HSRTP)

Specifically related to Children and/or Women:

National Strategy for Newborn and Child Survival in Ethiopia, 2015/16-2019/20

- National Adolescent and Youth Health Strategy

2.4.2. Levels, trends and differentials in key indicators

Ethiopia has experienced major gains in overall child survival, with a reduction in the under-five mortality rate, from 123 per 1,000 live births in 2005 to 55 per 1,000 live births in 2019.¹⁸⁴ Similar declines have occurred in the infant mortality rate, from 77 per 1,000 in 2005 to 43 per 1,000 in 2019. **Figure 15** shows mortality estimates derived from two sources: the 2019 EMDHS, and the UN Inter-agency Group on Mortality Estimation (IGME) (2017 estimates, released in 2018).¹⁸⁵ Although the values are slightly different between the two sources, they both reveal that neonatal mortality accounts for an extremely high proportion of under-five mortality.

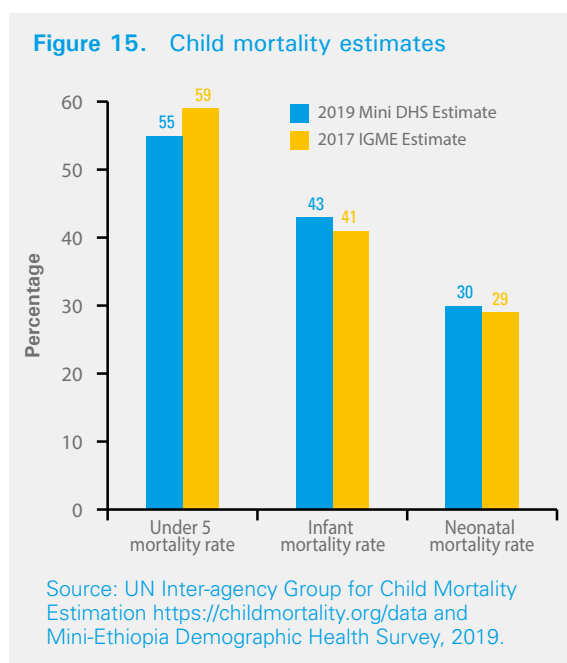


Figure 16 further illustrates trends and prospects in neonatal, infant and under-five mortality. As shown in the figure, neonatal mortality reduction has not occurred at the same pace as infant and under-five mortality reduction, and the neonatal mortality rate has not improved in recent years. As shown in **Figure 17**, deaths associated with pre-term birth, asphyxia, sepsis and congenital conditions

accounted for the majority of neonatal deaths in 2012. This, coupled with the fact that maternal mortality is declining but still very high (412 per 100,000, according to the 2016 EDHS), suggests that there is an unfinished agenda with respect to maximizing the coverage and quality of high-impact maternal and neonatal health interventions in the country.

The 2019 EMDHS does not yield disaggregated data on mortality, however the 2016 EDHS highlighted key disparities that warrant continued monitoring. One disparity relates to the higher rates of under-five, infant and neonatal mortality in boys. According to the 2016 EDHS, neonatal mortality (per 1,000) was 49 among boys and 26 among girls; infant mortality was 74 among boys and 47 among girls; and under-five mortality was 94 among boys and 68 among girls.¹⁸⁶ 2016 data also revealed that the under-five mortality rate was much lower in urban areas (66) than in rural areas (83), and that Afar (125), followed by Benishangul-Gumuz (98), Somali (94) and Dire Dawa (93) had the highest under-five mortality rates in the country.¹⁸⁷ In contrast, Addis Ababa (39) followed by Tigray (59) had the lowest under-five mortality rates. There were very strong correlations with levels of maternal education, a useful proxy of women's empowerment, and household wealth quintile in 2016 (mortality rates were much higher among the poorest children and among children of uneducated women than other categories of household wealth or education). Further investigation is required to ascertain whether the above disparities persist in the present day.

The 2019 EMDHS shows that coverage of several high-impact interventions has increased since 2016, but that national shortfalls continue. There is a continued disadvantage for rural children and women, the poorest children and women, women with little or no formal education, and women and children who reside in Afar and Somali (Annex 1). Some disparities are narrowing, but improvements have been driven by increased coverage in rural areas and

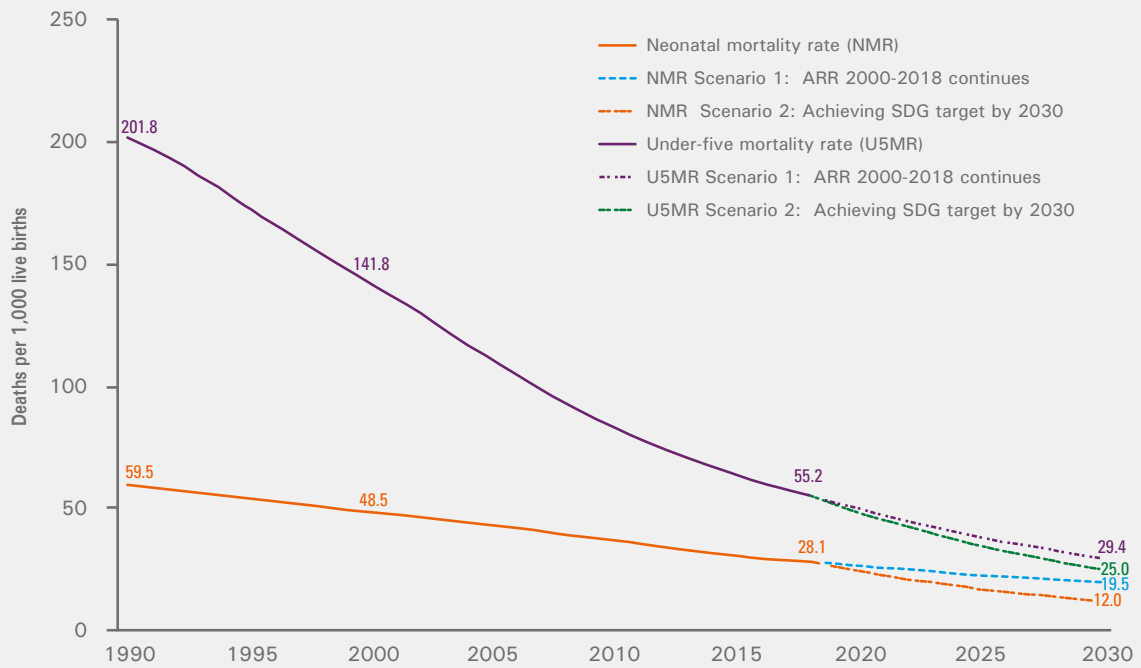
184 Ethiopian Public Health Institute and ICF. 2019. Ethiopia Mini Demographic and Health Survey 2019: Key indicators. Rockville, Maryland, USA: Ethiopian Public Health Institute and ICF.

185 United Nations Inter-agency Group for Child Mortality Estimation (UN IGME), Levels & Trends in Child Mortality: Report 2018. Estimates developed by UN IGME, UNICEF, New York, 2018.

186 Central Statistical Agency and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: Central Statistical Agency and ICF.

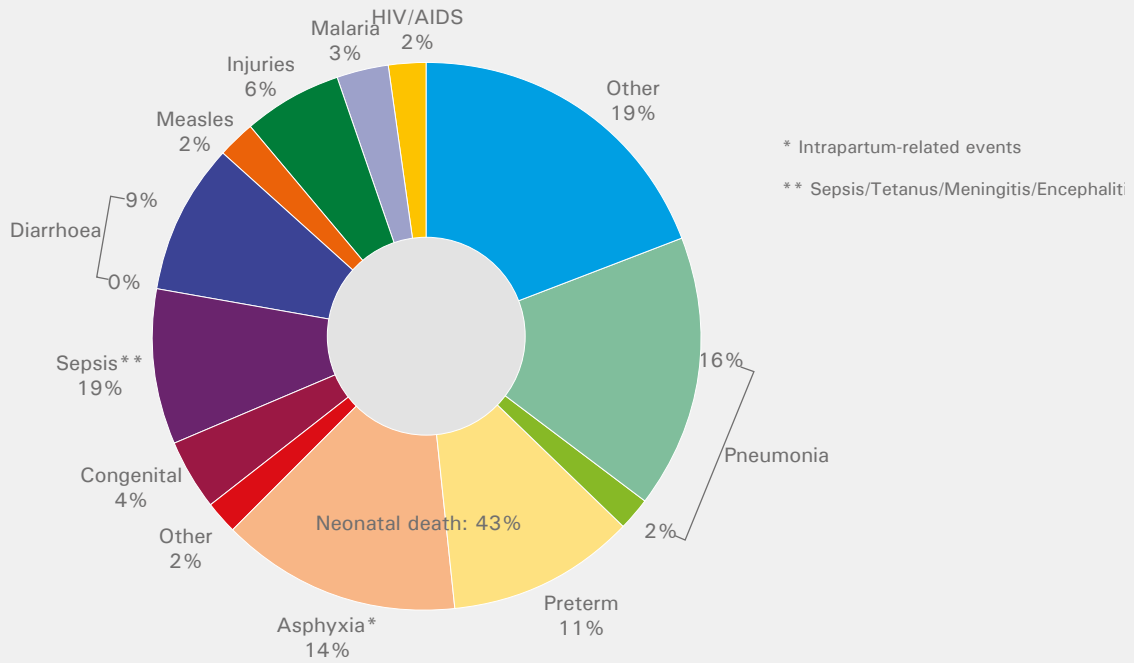
187 Ibid.

Figure 16. Child and neonatal mortality rates



Source: Ethiopia Demographic and Health Surveys, 2000-2016, Ethiopia Mini Demographic and Health Survey, 2019 and UN Inter-agency Group for Child Mortality Estimation. * UNICEF Data – <https://data.unicef.org/topic/child-survival/>.

Figure 17. Causes of deaths in children under-five years



Source: WHO/Child Health Epidemiology Reference Group, 2014.

in some regions that have consistently lagged behind the rest of the country. In contrast, there has been a stagnation, and in some instances a deterioration of coverage in urban areas and in parts of the country that were performing quite well, relative to the national average.

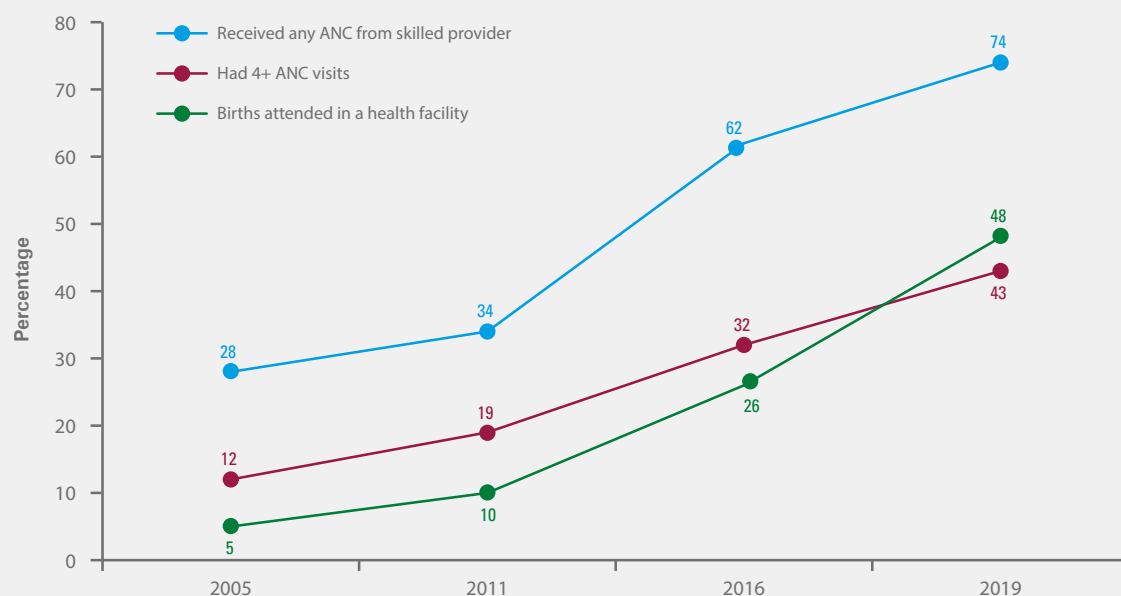
MODERN CONTRACEPTIVE use has consistently risen since 2005, from 14 per cent to 41 per cent among currently married women.¹⁸⁸ Disparities persist, although there have been increases in modern family planning use since 2016 among rural women, not urban women. Urban and rural rates were 49.8 per cent and 32.4 per cent, respectively in 2016; in 2019, they are 47.7 per cent and 37.7 per cent, respectively. Modern contraceptive use remains far lower in Somali (3.4 per cent) and Afar (12.7 per cent) than in other regions (30 per cent to 50 per cent).¹⁸⁹ Women in the richest households remain almost twice as likely to use modern family planning as the poorest women (51.1 per cent and 27.2 per cent, respectively),

and women with no formal education have a far lower rate (32 per cent) than women with any education (48 per cent to 54 per cent).

Figure 18 depicts trends in three indicators related to antenatal care (ANC) and skilled delivery since 2005.

ANC 1 coverage increased from 62.4 per cent in 2016 to 73.6 per cent in 2019, but in urban areas 2019 coverage (84.5 per cent) is actually lower than it was in 2016 (90.1 per cent).¹⁹⁰ In 2019, national ANC 4 coverage remains far lower (43 per cent) than national ANC 1 coverage, despite an increase since 2016 (when it was 31.8 per cent). There was a significant increase in the rate of SKILLED DELIVERY between 2016 and 2019, from 27.7 per cent to 49.8 per cent.^{191,192} As with antenatal care, this improvement occurred in rural areas (from 21.2 per cent to 42.5 per cent between 2016 and 2019), rather than in urban areas (from 80.1 per cent down to 72.1 per cent between 2016 and 2019). Regional

Figure 18. Coverage of antenatal and delivery care



Note: Percentage of women aged 15-49 who had a live birth in the five years before the survey (for the most recent birth).

Source: Ethiopia Mini Demographic and Health Survey, 2019.

188 Ethiopian Public Health Institute and ICF. 2019. Ethiopia Mini Demographic and Health Survey 2019: Key indicators. Rockville, Maryland, USA: Ethiopian Public Health Institute and ICF.

189 Ibid.

190 Ibid.

191 Ethiopian Public Health Institute and ICF. 2019. Ethiopia Mini Demographic and Health Survey 2019: Key indicators. Rockville, Maryland, USA: Ethiopian Public Health Institute and ICF.

192 Central Statistical Agency and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: Central Statistical Agency and ICF.

variations observed in the past hold true in 2019, although Oromia and Afar have seen substantial improvements in the rate of skilled delivery over the past three years (from 19.7 per cent to 43.7 per cent and from 16.4 per cent to 30.6 per cent, respectively), according to 2019 EMDHS data. **Table 5** presents FMOH administrative data for Ethiopian Fiscal Year (EFY) 2011 and shows that while there is regional variation, actual coverage rates in all regions are different from targets. In Harari and Addis Ababa, coverage rates exceed 100 per cent, suggesting data issues related to expected versus actual number of births.

POSTNATAL CARE within the first two days of birth remains an intervention area for intensified focus, with a national coverage rate of only 33.8 per cent, albeit twice that of 2016 coverage (16.5 per cent).

Wealth inequities still exist for some health indicators. In 2019, women from the highest wealth quintile are more than twice as likely to receive at least one antenatal visit, four times more likely to have a skilled delivery, and almost five times more likely to receive postnatal care than women in the lowest wealth quintile.

Universal access to child vaccination services is an important requirement for child survival. The percentage of children aged 12-23 months who received all **BASIC VACCINATIONS**¹⁹³ increased from 20.4



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193 As per the 2016 EDHS and 2019 EMDHS, all basic vaccinations include: one dose of BCG vaccine, three doses of DPT-HepB-Hib, three doses of polio vaccine and one dose of measles vaccine.

Table 5. Number of births attended and coverage of skilled birth attendance

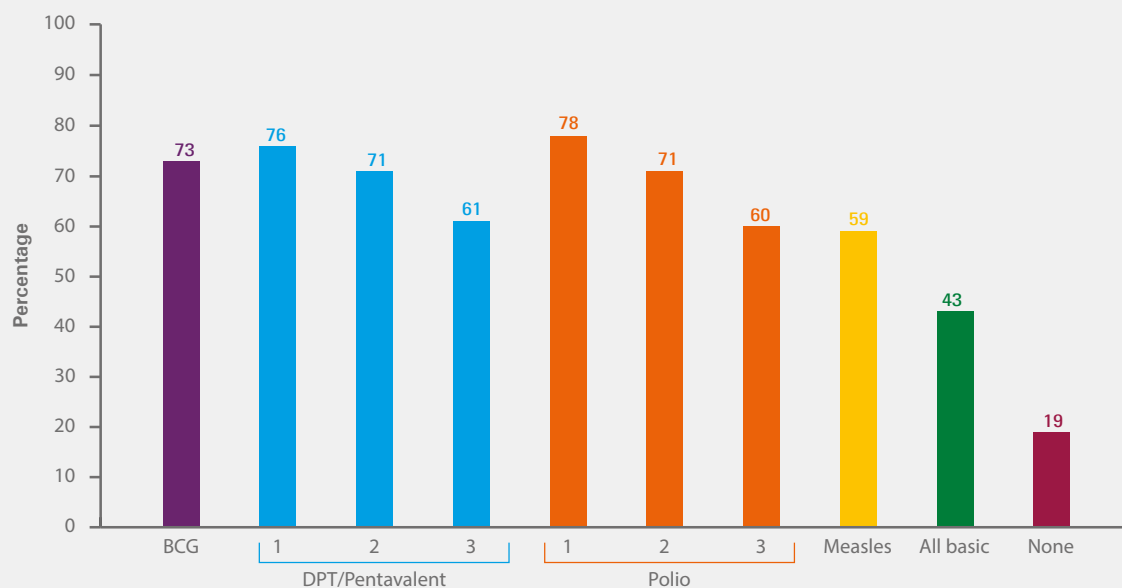
Sr #	Strategic Objectives & Performance Measures	Region										National		
		Tigray	Afar	Amhara	Oromia	Somali	B/ Gumuz	SNNPR	Gambela	Harreri	Dire Dawa		Addis Ababa	
5	Proportion of births attended by skilled health personnel	Eligible #	5,418,976	1,901,648	21,843,606	37,325,162	6,050,921	1,109,565	20,086,552	468,016	257,309	492,631	3,601,694	98,556,080
		Baseline #	184,505	54,577	736,130	1,295,183	191,209	37,836	694,995	14,040	7,951	15,863	83,919	3,316,209
		Performance #	131,117	21,180	469,679	784,063	66,147	18,084	516,738	5,101	9,473	114,892	11,427	2,147,901
		coverage %	73%	40%	65%	62%	35%	49%	76%	37%	100%	100%	74%	66%
	Target #	184,505	30,564	697,520	1,151,876	114,879	28,047	649,140	5,883	7,553	13,853	83,919	2,967,741	
	Target %	100%	59%	95%	89%	56%	74%	93%	42%	100%	100%	100%	89%	

per cent in 2005 to 43.1 per cent in 2019.¹⁹⁴ However, the low rate of coverage implies that almost 6 out of every 10 children are not protected against vaccine-preventable diseases. As shown in **Figure 19**, there are shortfalls in the coverage of all antigen-specific vaccinations, and dropouts remain an issue for vaccines that require repeated contact with the formal health system (e.g., Diphtheria, Pertussis and Tetanus (DPT)/ Pentavalent, and Polio vaccines).

children from the lowest wealth quintile, compared with 64.7 per cent of children from the highest wealth quintile, received all basic vaccinations.¹⁹⁶ Only 33.8 per cent of children with uneducated mothers received all basic vaccinations, compared with 65.1 per cent of children whose mothers have more than secondary education.

Strides are being made with respect to prevalence rates of certain **COMMUNICABLE**

Figure 19. Childhood vaccinations: percentage of children aged 12-23 months vaccinated



Source: Ethiopia Mini Demographic and Health Survey, 2019.

Even with this national shortfall in immunization, critical disparities exist that require programmatic attention. First, as with most outcomes, urban children aged 12-23 months are far more likely than their rural counterparts to receive all basic vaccinations (57.3 per cent and 36.9 per cent, respectively in 2019).¹⁹⁵ Regional variation is stark, with the percentage of children who received all basic vaccinations as low as 18 per cent to 19 per cent in Afar and Somali, and as high as 83.3 per cent in Addis Ababa (although lower than the 2016 rate of 89.2 per cent). Disparities also exist according to household wealth quintile and mother's level of education. According to the 2019 EMDHS, only 24.7 per cent of

DISEASES. For example, Health Management Information System data managed by FMOH shows that tuberculosis and malaria health status outcomes have generally improved since 2012, and Ethiopia has been lauded for reductions in its malaria caseload.¹⁹⁷ The 2016 EDHS documented that HIV prevalence among women and men aged 15-49 years declined from 1.5 per cent in 2011 to 0.9 per cent in 2016. However, women of reproductive age still face twice the risk of HIV infection as men, and HIV prevalence is seven times higher in urban areas (2.9 per cent) than in rural areas (0.4 per cent).¹⁹⁸ HIV prevalence has been

194 Ethiopian Public Health Institute and ICF. 2019. Ethiopia Mini Demographic and Health Survey 2019: Key indicators. Rockville, Maryland, USA: Ethiopian Public Health Institute and ICF. Table 6.

195 Ibid.

196 Central Statistical Agency Ethiopia and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: Central Statistical Agency and ICF. Table 10.3.

197 World Health Organization. 2018. World Malaria Report 2018. Geneva: WHO. Licence: CC BY-NC-SA 3.0 IGO.

198 SPRI Global. 2019. Trends of Change in Gender Equality in Ethiopia (Policy Brief).

consistently higher in Addis Ababa, Gambella and Harari than in other regions.

Approximately 1 per cent of under-five deaths in Ethiopia can be attributed to malaria,¹⁹⁹ with Gambella having the highest prevalence rate (21 per cent according to a rapid diagnostic test, and 7 per cent according to microscopy).²⁰⁰ Since 2004, the government has distributed insecticide-treated nets free of charge as a malaria prevention measure and has offered malaria diagnosis free of charge in the public sector.²⁰¹ According to successive Malaria Indicator Surveys, the proportion of households owning at least one insecticide-treated net increased from 47 per cent in 2011 to 64 per cent in 2015.²⁰² However, Ethiopia did not meet the operational universal coverage target of one net per two persons at risk by 2017.²⁰³ Ownership of insecticide-treated nets is lowest in Somali (51 per cent) and much lower among the poorest households than the wealthiest households. There has been no progress in the proportion of children from the poorest households sleeping under insecticide-treated nets (32 per cent in 2011 and 31 per cent in 2015). Regarding the urban/rural divide, this figure was 60 per cent in urban areas and 44 per cent in rural areas.

In 2017, an estimated 610,000 Ethiopian people were living with HIV, with children accounting for 10 per cent of the population living with HIV.²⁰⁴ It is noteworthy that 24 per cent of all AIDS-related deaths are among children, and 34 per cent of people with new infections are children, according to UNAIDS 2018 HIV estimates for Ethiopia. Among infected children, antiretroviral therapy (ART) coverage (34 per cent) is well below the

national target of having 85 per cent of children living with HIV on ART by 2020.^{205,206} Estimates for the percentage of pregnant women living with HIV who had received antiretrovirals (ARVs) for the prevention of mother-to-child transmission (PMTCT) vary. Using 2017 data, this figure was estimated at 59 per cent.²⁰⁷ In 2019, UNAIDS estimates suggest that PMTCT coverage ranged from 63 per cent to 95 per cent in 2018.²⁰⁸ Coverage of early infant diagnosis of HIV is estimated at 69 per cent. There are many reasons why large numbers of HIV-positive pregnant women have not received ARVs. Two such reasons are the low levels of knowledge on pregnancy-related HIV transmission and the fact that many pregnant women living with HIV are not identified as having HIV.²⁰⁹

TIMELY CARE SEEKING FOR COMMON CHILDHOOD ILLNESSES is crucial to child survival. The 2016 EDHS noted that 6.6 per cent of under-fives had symptoms of acute respiratory infection in the two weeks before the survey, but only 3 out of 10 of those children sought treatment. Rates of care seeking for fever and diarrhoea were higher, albeit far from optimal: 14 per cent of children under the age of 5 reportedly had fever in the two weeks before the survey, with 35 per cent seeking treatment from a health facility or provider, while 12 per cent of children under the age of 5 were reported to have diarrhoea in the two weeks before the survey, and 44 per cent seeking treatment. The rate of recommended home-based practices for diarrhoea was also low, with only 46 per cent of children with diarrhoea receiving some form

199 See UNICEF, *Malaria in Africa - UNICEF Data*, 2018, available at: <https://data.unicef.org/topic/child-health/malaria/> (last accessed: 10 Jan. 2019).

200 *Ibid.* p. 54.

201 World Health Organization. 2018. *World Malaria Report 2018*. Profile Ethiopia, available at: https://www.who.int/malaria/publications/country-profiles/profile_eth_en.pdf?ua=1 (last accessed: 10 Jan. 2019).

202 Malaria Indicator Surveys, 2011 and 2015.

203 World Health Organization. 2018. *World Malaria Report 2018*. Geneva: WHO. Licence: CC BY-NC-SA 3.0 IGO.

204 Ethiopian Public Health Institute. 2017. *HIV Related Estimates and Projections for Ethiopia – 2017*.

205 Federal Democratic Republic of Ethiopia. 2014. *HIV/AIDS Strategic Plan 2015-2020 in an Investment Case Approach*, p. 47.

206 Federal Ministry of Health and FHAPCO. 2018. Draft Report. 'Mid-Term Review of the HIV/AIDS Strategic Plan 2015-2020 in an Investment Case Approach', and Baseline Assessment of Viral Hepatitis, pp. x and xi.

207 UNICEF. 2018. *Monitoring the Situation of Children and Women*, available at: <https://data.unicef.org/topic/hivaids/global-regional-trends/> (last accessed 10 Jan. 2019).

208 UNAIDS. *Ethiopia Country Factsheet 2018*. <https://www.unaids.org/en/regionscountries/countries/ethiopia>. Retrieved 13 Aug 2019.

209 Central Statistical Agency Ethiopia and ICF. 2016. *Ethiopia Demographic and Health Survey 2016*. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: Central Statistical Agency and ICF.

of oral rehydration therapy, while 39 per cent received oral rehydration therapy or increased liquids.

2.4.3. Drivers of identified shortfalls and differentials

Figure 20 highlights factors that contribute to identified shortfalls and inequities related to health. Structural factors such as public expenditure on health are highly salient to achieving improved health outcomes in children and women. However, effective allocation of existing resources across interventions and/or health system pillars warrants further attention. The map in **Figure 21** shows the distribution of health facilities according to facility type in 2014.

The Federal Government has invested heavily in expanding the availability of service delivery sites in the health sector. However, quality transformation in healthcare has also been a priority under HSTP, and there has been a proliferation of quality initiatives and processes. However, a 2016 Service Availability and Readiness Assessment highlighted major shortcomings with respect to basic health facility readiness. For example, only 30 per cent of health facilities had improved water sources, with a huge disparity between urban and rural health facilities (76 per cent and 20 per cent, respectively).²¹⁰

Underlying factors related to quality and coordination remain prominent contributors to shortfalls and inequities, as depicted in Figure 20. For example, as noted in the HSTP mid-term review (2018), there is no coherent, sector-wide plan and approach to improve health worker skills (both clinical and non-clinical), and there is a lack of clarity regarding health worker regulation and oversight.²¹¹ The public sector-private sector interface is another area for optimization. The HSTP mid-term review highlighted shortcomings related to procurement and supply-chain management.²¹²

The Health Extension Programme is in many ways the backbone of the public health system. A process has already been started to optimize this programme and formulate contextually appropriate adaptations to better address the needs of the target population(s) in different parts of the country (e.g., pastoralists in Somali and Afar).²¹³ The Health Extension Programme is at a critical juncture, with issues being examined in regard to support for, and development and productivity of, the health extension worker cadre.²¹⁴

It should be noted that factors in the causal pathway are not all supply related; access barriers also impact demand. Financial accessibility is one such issue. Two health-sector initiatives, the Community-Based Health Insurance (CBHI) scheme and the fee waiver system, have been rolled out to address financial access barriers faced by the poorest segments of the population. Of the 375 CBHI woredas, 289 woredas had initiated health service provision to CBHI enrollees, and health service utilization increased from 2.1 million in 2008 EFY to 5.6 million in 2009 EFY.²¹⁵ However, coverage of those programmes is far below national targets. For example, in 2018 CBHI was introduced in 39 per cent of all woredas, far below the end-of-HSTP target of 80 per cent of all woredas.²¹⁶ Hence, while progress is being made in reducing financial barriers, the scale of current efforts is not yet sufficient.

There are several social determinants of health that mediate access and have a direct bearing on health care seeking, and thus health outcomes. Geographical barriers still exist in regions such as Afar and Somali. Constraints on mobility, for example, resulting from conflict or civil unrest in places such as Oromia can also have a disruptive effect on health care and health care seeking. Social and gender norms are demand-side factors that can contribute to shortfalls and inequities. For example, nationally, women's participation in decisions about their own health

210 Ethiopian Public Health Institute. 2017. Service Availability and Readiness Assessment 2016, Table 2.1.1 Ibid.

211 Ethiopia Health Sector Transformation Plan (HSTP) (2015/16-2019/20 GC or 2008-2012 EFY) Mid-Term Review Report: Volume 1, 2018.

212 Ibid.

213 Ibid.

214 Assefa, Yibeltal, Gelaw, Yalemzewod, Hill, Peter, Taye, Belaynew and Van Damme, Wim. 2019. 'Community Health Extension Program of Ethiopia, 2003-2018: Successes and challenges toward universal coverage for primary healthcare services', *Globalization and Health*, 15. 10.1186/s12992-019-0470-1.

215 Ibid.

216 Ibid.

Figure 20. Causal pathway for identified shortfalls and inequities related to health

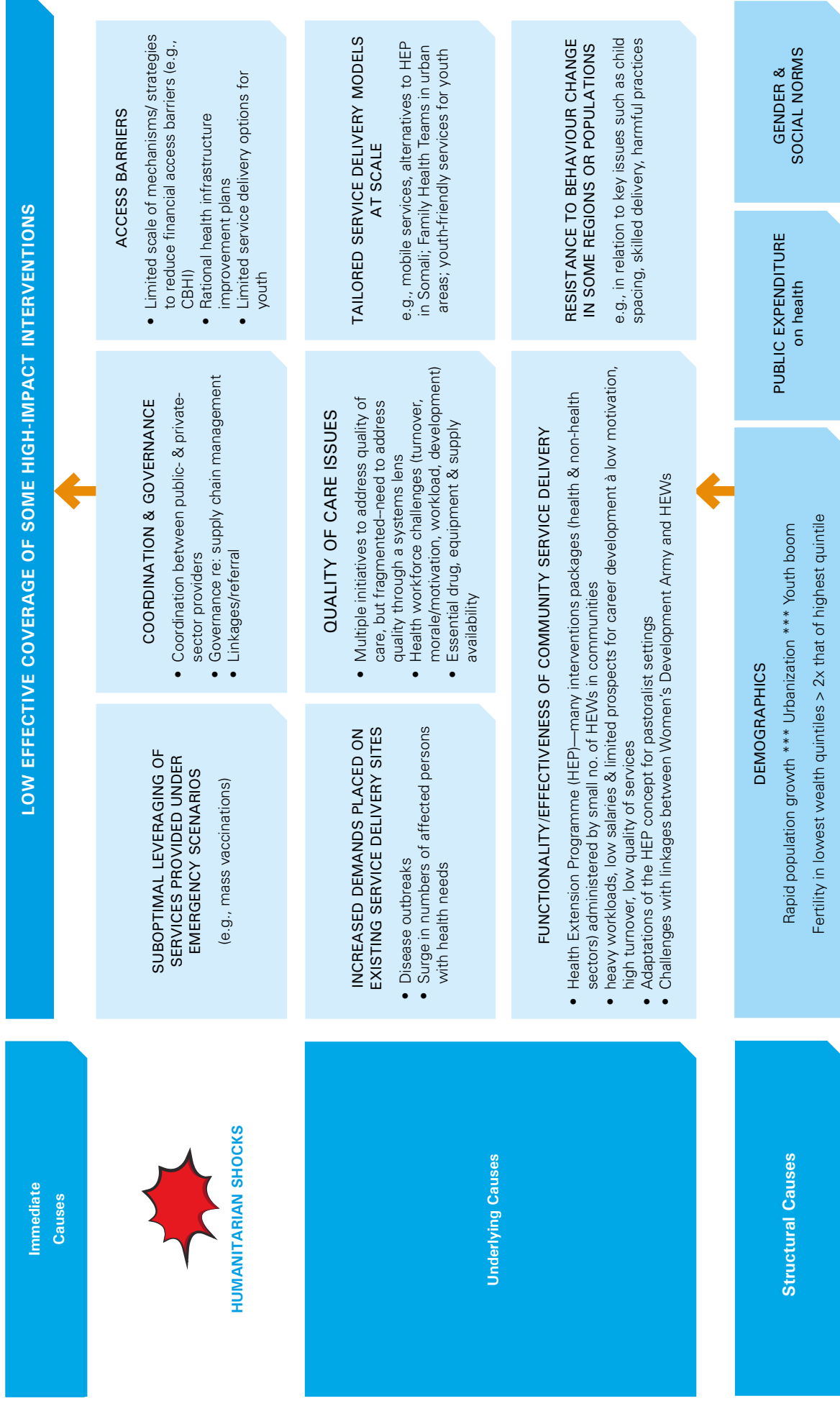
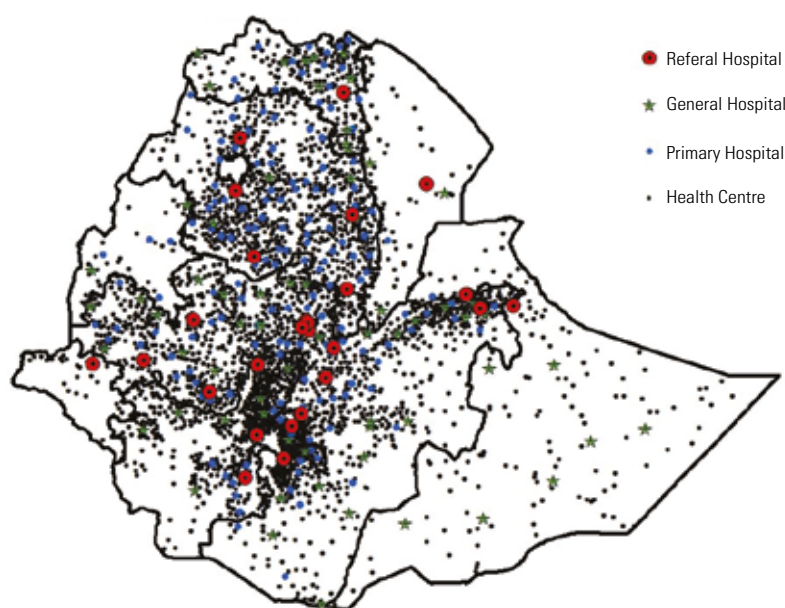


Figure 21. Distribution of health facilities by type

Source: Ethiopian Service Provision Assessment Plus 2014.

has risen significantly over time, from 66 per cent in 2005 to 81 per cent in 2016.²¹⁷ However, Somali, SNNP and Afar have consistently had far lower rates of women's participation in decision making than other regions.

2.4.4. Sector-specific recommendations

1. Further investigate what specifically is driving higher mortality rates among boys than girls in order to identify specific points of intervention. The investigation should include a critical examination of social determinants of health, in addition to other factors.
2. In light of consistently high neonatal mortality rates, despite declines in other forms of early child mortality, identify and address barriers and bottlenecks related to the facility-community interface, social norms, and sub-optimal practices that compromise newborn health and survival. Models already in place in Ethiopia, for example Community Scorecards, can be used to enable communities to create mutual accountability with health facilities and local government structures in relation to newborn health and survival.
3. At regional and woreda levels, strengthen the quality and use of administrative data (Health Management Information System) for health coordination, governance and results accountability between public-sector and other health care providers (private, CSO/NGO), as well as different levels of service delivery (health post, health centre, hospital).
4. With the recent proliferation of quality improvement initiatives in the health sector, and noteworthy patterns in health care seeking (e.g., reliance on private-sector providers by particular segments of the population for particular types of health services), pursue public-private partnerships that institutionalize quality improvement standards and strategies. Foster cooperation across different health providers and levels of care. Explore ways that regulation and certification can facilitate harmonization and cooperation with the private sector.
5. Accelerate the scale up of programmes and/or service delivery modalities that have demonstrated effectiveness in reaching hard-to-reach and/or highly vulnerable sub-sets of children (e.g., pastoralists, extremely poor children in urban and rural settings). In the spirit of leaving no one behind, those efforts should be rooted in strategies that also entail inclusion of

217 SPRI Global. 2019. Trends of Change in Gender Equality in Ethiopia (Policy Brief).

males and females (children and adults) that are members of the intended target populations in the planning, monitoring and supportive supervision sessions.

6. Conduct an exercise to rationalize health sector resources based on disease burden, performance vis-à-vis RMNCH outcomes, and identified health system gaps (e.g., supply chain, workforce at different levels of the health system). Insights from the exercise can, in turn, inform strategies around public finance for children.
7. Develop acceleration plans focusing on underlying and structural factors that contribute to lagging performance in key health outcomes in particular regions (e.g., Somali, Afar), as well as specific administrative areas (e.g., woredas) within those regions. In light of wealth and geographic disparities in some outcomes, target the expansion of social protection coverage (e.g., CBHI, PSNP) in geographies with lagging health indicator performance.
8. In light of the stagnation and/or deterioration of intervention coverage in urban settings, review current service delivery modalities in urban areas, as well as social determinants of health that impede access to and use of essential health services in those settings. Examine the impact that population movement (rural-urban migration, settlement of displaced persons in urban/peri-urban areas) is having on urban health outcomes.

2.5. Nutrition

Ethiopia is lauded globally for its nutrition strides in the 21st century. According to EDHS and EMDHS data, the national prevalence of chronic malnutrition (stunting) in children under 5 years was 58 per cent in 2000, 38 per cent in 2016, and is currently 37 per cent in 2019.^{218,219,220} Rates for child wasting (a

measure of acute malnutrition) were 12 per cent in 2000, 10 per cent in 2016, and are currently 7 per cent in 2019.^{221,222,223}

Ethiopia has some of the highest absolute numbers of children who are stunted and wasted worldwide.²²⁴ Its child malnutrition rates exceed point-prevalence estimates for East Africa and the Africa region as a whole (average stunting rates estimated for (a) East Africa: 35.2 per cent, with lower and upper limits of 31.4 per cent and 39.3 per cent, respectively and (b) Africa as a whole: 30 per cent, with lower and upper limits of 27.6 per cent and 32.3 per cent, respectively; average wasting rates estimated for (a) East Africa: 6 per cent, with lower and upper limits of 4.3 per cent and 8.3 per cent, respectively and (b) Africa as a whole: 7.1 per cent, with lower and upper limits of 6 per cent and 8.2 per cent, respectively).²²⁵ In addition, child malnutrition is

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218 Central Statistical Authority [Ethiopia] and ORC Macro. 2001. Ethiopia Demographic and Health Survey 2000. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Authority and ORC Macro.

219 Central Statistical Agency and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: Central Statistical Agency and ICF.

220 Ethiopian Public Health Institute and ICF. 2019. Ethiopia Mini Demographic and Health Survey 2019: Key indicators. Rockville, Maryland, USA: Ethiopian Public Health Institute and ICF.

221 Central Statistical Authority [Ethiopia] and ORC Macro. 2001. Ethiopia Demographic and Health Survey 2000. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Authority and ORC Macro.

222 Central Statistical Agency Ethiopia and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: Central Statistical Agency and ICF.

223 Ethiopian Public Health Institute and ICF. 2019. Ethiopia Mini Demographic and Health Survey 2019: Key indicators. Rockville, Maryland, USA: Ethiopian Public Health Institute and ICF.

224 UNICEF, World Health Organization, International Bank for Reconstruction and Development/The World Bank. 2019. Levels and Trends in Child Malnutrition: Key findings of the 2019 edition of the Joint Child Malnutrition Estimates. Geneva: WHO. Licence: CC BY-NC-SA 3.0 IGO.

225 Ibid.

still estimated to contribute to over 50 per cent of all infant and child deaths in Ethiopia.²²⁶

2.5.1. Policy and stakeholder landscapes

The second National Nutrition Programme (NNP II 2016-2020) is the current five-year roadmap for nutrition improvement in the country. However, there are several other policies, strategies and guidelines of relevance to nutrition efforts, as depicted in **Figure 22**.

In 2010, Ethiopia joined Scaling Up Nutrition (SUN), a global movement that advocates for multi-sectoral, multi-stakeholder responses to nutrition improvement.²²⁷ Ethiopia's National Nutrition Coordination Body is the main nutrition coordination mechanism, with FMOH currently serving as the convener of that multi-stakeholder, multi-sectoral body. There is a vision for the model to be replicated at the regional level, however that vision is not yet realized.

There is a special coordination arrangement for nutrition-related humanitarian responses, with the Emergency Nutrition Coordination Unit, which is housed within the Ministry of Agriculture, as the convener. An FMOH analysis of nutrition financing from 2013/2014 to 2015/2016 (E.Y. 2006-2008) sheds light on the nature of inputs to Ethiopia's nutrition response. During the period in question, nutrition expenditure nearly doubled, to a budgeted amount of US\$ 455 million, with almost three quarters of that amount earmarked for nutrition-sensitive programmes (e.g., WASH, social safety net programmes).²²⁸ The government managed 70 per cent of those resources, but development partners contributed the majority of funds (US\$ 405 million out of US\$ 455 million).

²²⁶ NNP II, p. 18.

²²⁷ Scaling Up Nutrition. 2018. Ethiopia Country Profile 2018. Retrieved from: https://scalingupnutrition.org/wp-content/uploads/2018/12/Ethiopia_Country_Profile_2018.pdf, 10 August 2019.

²²⁸ Federal Democratic Republic of Ethiopia, Ministry of Health. Tracking Funding for Nutrition in Ethiopia Across Sectors. Addis Ababa, Ethiopia. Cited in UNICEF Eastern and Southern Africa Regional Office and Johns Hopkins Bloomberg School of Public Health. 2019. 'Complementary Feeding Landscape Analysis' (draft).

Leveraging FMOH's Health Extension Programme, community-level nutrition service delivery is institutionalized in Ethiopia,²²⁹ with the exception of parts of the country where the Health Extension Programme is not a key feature of health service delivery, for example Somali.

Social protection experiences, such as the country's Third Productive Safety Net Programme (PSNP 3) have yielded valuable lessons with respect to leveraging the social protection mechanism for nutrition improvement.²³⁰ Under PSNP 3, the quality of children's diets and child malnutrition levels did not improve in beneficiary households.²³¹ As a result, PSNP 4 contains several features that focus on achieving better nutrition impacts. These include Permanent Direct Support for PSNP clients receiving 12 rather than 6 months of cash or food transfers of larger amounts; the temporary transfer of primary caregivers of malnourished children into Direct Support during the child's treatment for malnutrition; and the use of soft conditions on Direct Support clients to encourage their fulfilment of pre-defined activities, such as health and nutrition care seeking.²³²

Levels, trends and differentials in key indicators

²²⁹ UNICEF Eastern and Southern Africa Regional Office and Johns Hopkins Bloomberg School of Public Health. 2019. 'Complementary Feeding Landscape Analysis' (draft).

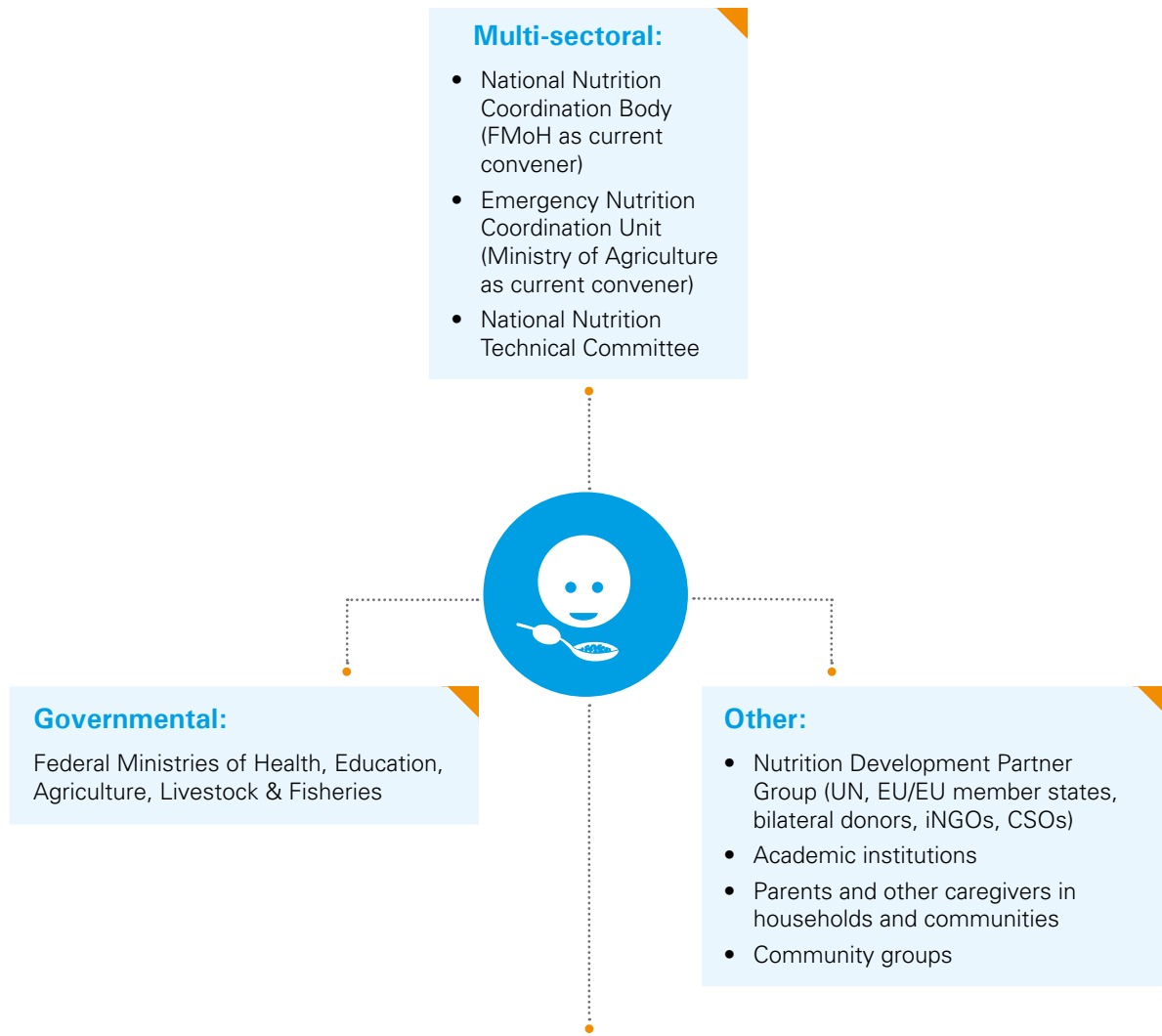
²³⁰ And other services, such as health care, education, social protection, WASH and child protection services, including social welfare, legal/justice assistance, violence against children services, etc.

²³¹ UNICEF ECO. 2017. National Social Protection Budget Brief: 2011-2016, p. 4. See also UNICEF ECO, Annual Report 2017, Ethiopia, p. 5.

²³² The following are features of PSNP 4 that explicitly address nutrition factors: (a) Training Guide on Gender, Social Development and Nutrition Mainstreaming in PSNP for social workers, health extension workers and development agents on the proper implementation of gender and social development and nutrition provisions; (b) Permanent direct support to PSNP clients receiving 12 rather than 6 months of cash or food transfers of larger amounts; (c) Temporary transfer of pregnant and lactating women (starting from the first ANC visit until one year after giving birth) out of the public works component of PSNP into direct support as a means of reducing their work burden and encouraging optimal healthcare seeking; (d) Temporary transfer of primary caregivers of malnourished children into direct support during the child's treatment for malnutrition; (e) Use of soft conditions (referred to as co-responsibilities) with direct support clients (temporary and permanent) to encourage their fulfilment of pre-defined activities e.g., health and nutrition care seeking).

Figure 22. Stakeholder and policy landscape related to nutrition in Ethiopia

KEY ENTITIES AND STRUCTURES IN THE CURRENT NUTRITION LANDSCAPE



THE CURRENT POLICY AND LEGAL LANDSCAPE RELATED TO NUTRITION

For the General Population:

- Second National Nutrition Program (NNP II) 2016-20
- National Food & Nutrition Policy (2019)
- Nutrition-Sensitive Agriculture Strategy (2016)
- Agricultural Growth Programme II (2017)
- One WASH National Programme (OWNP)
- Integrated Urban Sanitation & Hygiene Strategy and Implementation Guidelines

Specifically related to Children and/or Women:

- Baby and Mother WASH Implementation Guidelines (2017)
- School Health & Nutrition Strategy (2012)
- School Feeding Strategy

Annex 1 contains tables that highlight key differentials in selected nutrition indicators, according to gender, residence, household wealth quintile and region.

NUTRITIONAL STATUS OUTCOMES—As stated at the beginning of this chapter, there have been strides with respect to chronic malnutrition. However, rates are still high and the pace of reduction must be accelerated in order to meet World Health Assembly nutrition targets. As shown in **Figure 23**, the current average annual rate of reduction (AARR), 1.89 per cent, is far lower than the required AARR (4.84 per cent) to achieve the 2025 stunting target of 22.6 per cent.

Particular sub-sets of children experience higher malnutrition rates than other children. **Figure 24** is a graphical depiction of key disparities in child stunting. According to the 2019 EMDHS, under-five stunting rates are highest for 24- to 35-month-olds (45.1 per cent), children in the two lowest wealth quintiles (each 41.9 per cent), children whose mothers have no formal education (41.7 per cent), rural children (40.6 per cent) and boys (40.2 per cent). Large disparities also exist by region, with Tigray (48.7 per cent), Afar (43 per cent), Amhara (41.3 per cent) and Benishangul-

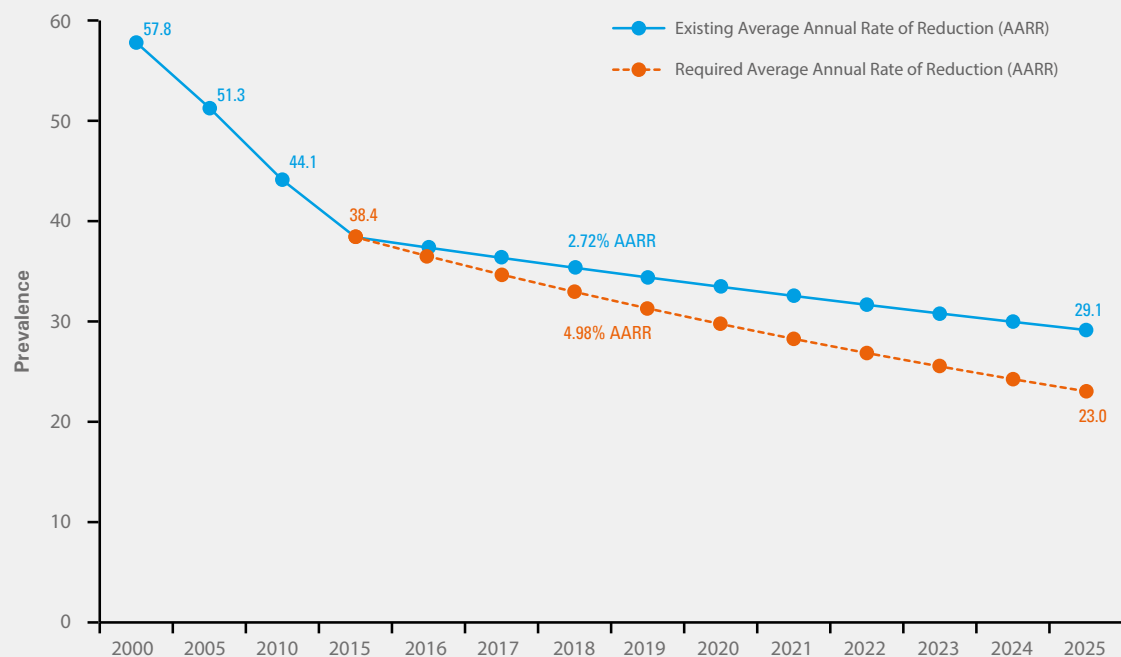


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Gumuz (40.8 per cent) having the highest stunting rates of all regions.

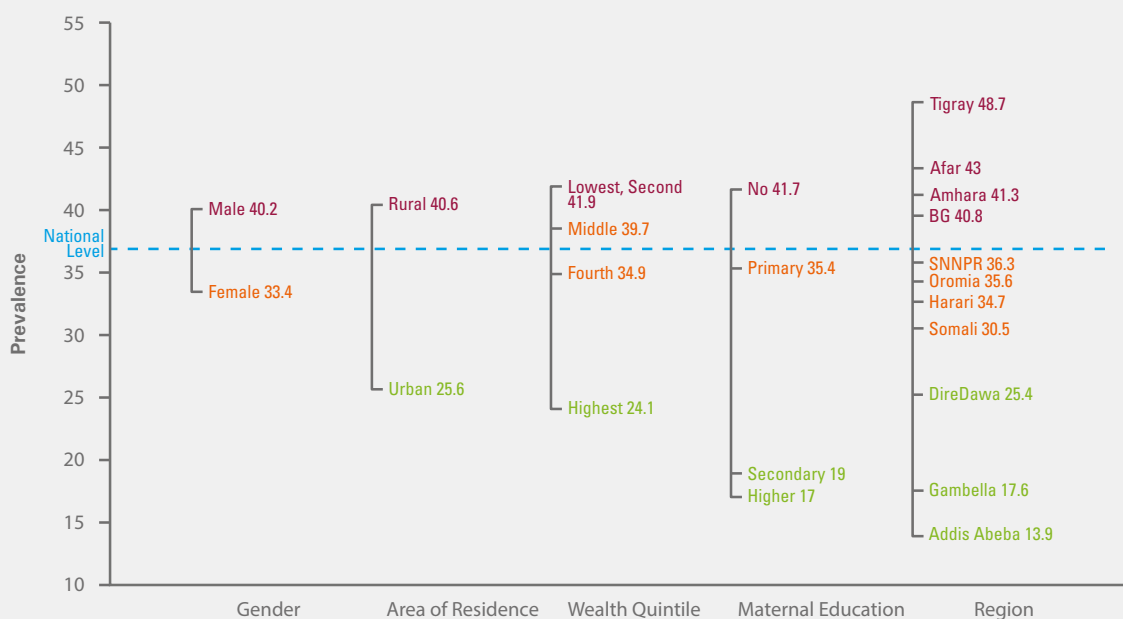
One out of every five children in Somali (21.1 per cent) is wasted, while emergency-level conditions also exist in Afar and Gambella, where wasting rates are 13.9 per cent and 12.5 per cent, respectively. As with stunting, the current AARR of 0.5 per cent for wasting is far lower than the required AARR of 6.6 per cent to achieve the World Health Assembly wasting target by 2025 (**Figure 25**).

Figure 23. Child stunting trends and progress towards World Health Assembly targets



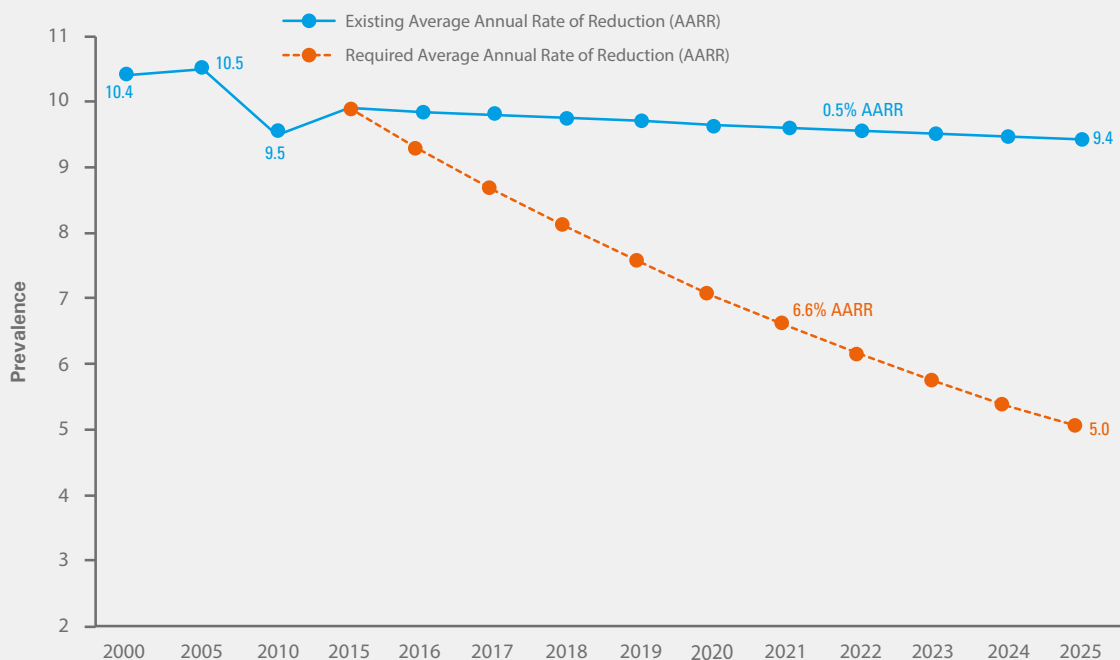
Source: UNICEF's calculations based on Ethiopia Demographic and Health Surveys, 2000-2016, Ethiopia Mini Demographic and Health Survey, 2019.

Figure 24. Disparities in stunting



Source: Ethiopia Demographic and Health Survey, 2016 and UNICEF Disparities Analysis, 2018.

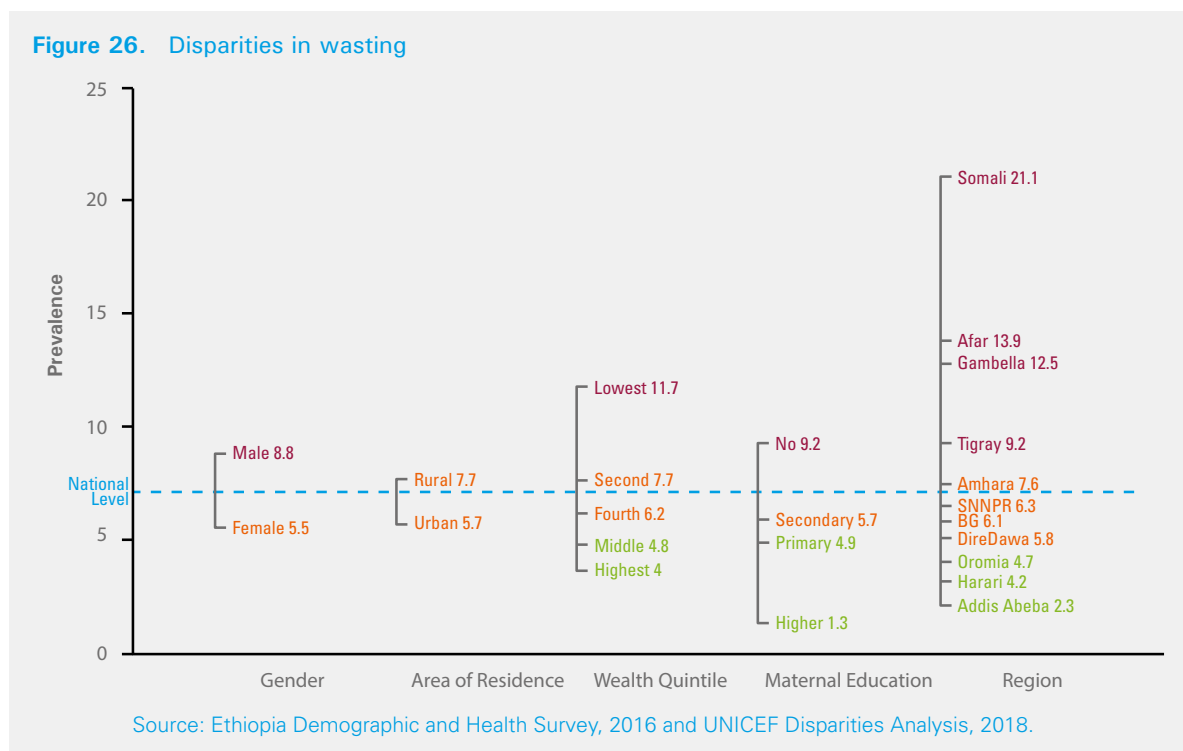
Figure 25. Child wasting trends and progress towards World Health Assembly targets



Source: Ethiopia Demographic and Health Surveys, 2000-2016, Ethiopia Mini Demographic and Health Survey, 2019.

Figure 26 is a graphical depiction of key disparities in child wasting. Children in the lowest wealth quintile have a wasting prevalence that far exceeds children in other quintiles (11.7 per cent compared with 4 per cent to 7.7 per cent). Boys are more likely to be wasted than girls (8.8 per cent and 5.5 per

cent, respectively), and children in rural areas are more likely to be wasted than children in urban areas (7.7 per cent and 5.7 per cent, respectively). A child whose mother has no formal education is seven times as likely as a child whose mother has more than a secondary education to be wasted (9.2 per cent and

Figure 26. Disparities in wasting

1.3 per cent, respectively). With a national prevalence of 0.6 per cent, overweight/obesity is not a major form of malnutrition in Ethiopia, although children in Addis Ababa have the highest rate (2.5 per cent).

Women's nutritional status is a crucial component of Ethiopia's efforts to end malnutrition in all its forms. According to the 2016 EDHS, roughly one out of every four women aged 15-49 years (22.4 per cent) is thin (body mass index (BMI) <18.5 kg/m²), and 7.6 per cent are overweight or obese (BMI ≥25).²³³ 2016 data showed stark urban-rural and wealth disparities in women's overweight/obesity (21.4 per cent in urban women, compared with 3.5 per cent in rural women; 19.6 per cent among women in the highest wealth quintile compared with 2.5 per cent of women in the lowest wealth quintile). In light of Ethiopia's rapid urbanization, overweight and obesity, particularly in women, are nutritional outcomes that warrant close monitoring and programmatic action.

Anaemia affected almost one out of every four women of reproductive age (23.6 per cent) in 2016. This was a marked increase from the

233 Central Statistical Agency and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: Central Statistical Agency and ICF. Table 11.10.1.

17 per cent anaemia prevalence documented in 2011, and signals a public health concern. In 2019, only 60 per cent of women took iron tablets during pregnancy for their most recent live birth, up from 42 per cent in 2016.^{234,235} The 2016 EDHS showed that anaemia takes an even greater toll on children, affecting 56.9 per cent of children aged 6-59 months (67.8 per cent of children in the lowest wealth quintile).²³⁶ Although anaemia affects the majority of children nationwide, particular regions had anaemia prevalence rates in children that far exceeded the national average, for example Somali (82.9 per cent), Afar (74.8 per cent), Dire Dawa (71.5 per cent), Harari (67.9 per cent) and Oromia (65.5 per cent).

The low 2019 coverage of **VITAMIN A SUPPLEMENTATION** among children aged 6-59 months (47.1 per cent), which is not vastly different from the rate documented in 2016 (44.7 per cent), suggests that anaemia might not be the only micronutrient deficiency of

234 Ethiopian Public Health Institute and ICF. 2019. Ethiopia Mini Demographic and Health Survey 2019: Key indicators. Rockville, Maryland, USA: Ethiopian Public Health Institute and ICF.

235 Central Statistical Agency and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: Central Statistical Agency and ICF.

236 Ibid. Table 11.7.

concern among children.^{237,238} In 2019, vitamin A supplementation rates are lowest among children aged 6-8 months (19.3 per cent), children of females aged 15-19 years (31.4 per cent), children in Afar (32.4 per cent) and children in the lowest wealth quintile (35.6 per cent).

BREASTFEEDING—Breastfeeding is one of the most cost-effective practices to improve child health, nutrition and development outcomes. In Ethiopia, the rate of exclusive breastfeeding has risen since 2005 (when it was 49 per cent). However, only 59 per cent of children under 6 months are exclusively breastfed (as per WHO recommendations) in 2019, which indicates negligible improvement over the 2016 figure (58 per cent).²³⁹ The 2016 EDHS estimated that, on average, a child in Ethiopia was breastfed for 4.5 months, although the average duration of exclusive breastfeeding was less than three months in Afar, Oromia, Gambella and Addis Ababa. In addition, as described below, the quality of children's diets is extremely low.

MINIMUM ACCEPTABLE DIETARY STANDARDS—Ethiopia has the lowest rates of minimum dietary diversity (12 per cent) and minimum acceptable diet (7.2 per cent) in East and Southern Africa.²⁴⁰ There is an urban-rural divide in minimum dietary diversity, with urban households faring much better than rural households (27.3 per cent and 9.8 per cent, respectively), although dietary diversity is sub-optimal in both urban and rural areas.²⁴¹ Even in agriculturally productive parts of the country, there is limited availability of diverse foods, particularly fruits and vegetables.²⁴² Other disparities are also evident, for example across all age groups there is extensive gender

inequality in both food and micronutrient deprivation.²⁴³ Regional variations are stark, with the proportion of children who receive the minimum acceptable diet ranging from 2 per cent to 3 per cent in Afar, Somali and Amhara, to 27 per cent in Addis Ababa.²⁴⁴ Mother's level of education and household wealth are positively correlated with the quality of diets. However, the issue of minimum acceptable dietary standards applies to all children, even children whose mothers have secondary education (15 per cent, compared to 5.4 per cent among children whose mothers have no formal education), and children in the highest wealth quintile (16.2 per cent, compared to 2.8 per cent among the poorest children).

NUTRITION THROUGH A HUMANITARIAN LENS—Humanitarian emergencies have further exacerbated conditions vis-à-vis nutrition. There is particularly strong evidence of an elevated malnutrition burden among emergency-affected children. Data from humanitarian response actors on the number of children under 5 years admitted for therapeutic treatment of acute malnutrition indicate that the greatest burden exists in Somali and Afar regions, with those two regions accounting for two thirds of acute malnutrition admissions in the country in 2018. This is followed by selected zones of Oromia (e.g., East and West Harerge, West Guji, Bale and Borena), and parts of SNNP, northern Amhara and eastern Tigray.²⁴⁵

A nutrition assessment of IDP sites in West Guji zone found a 27 per cent global acute malnutrition prevalence and a 3 per cent severe acute malnutrition prevalence among children under 5 years—far above the emergency thresholds set by WHO. Malnutrition was also high among women in those sites, where 51 per cent of the pregnant and breastfeeding mothers were found to be malnourished.²⁴⁶

237 Ethiopian Public Health Institute and ICF. 2019. Ethiopia Mini Demographic and Health Survey 2019: Key indicators. Rockville, Maryland, USA: Ethiopian Public Health Institute and ICF.

238 Central Statistical Agency and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: Central Statistical Agency and ICF. Table 11.8.

239 Ethiopian Public Health Institute and ICF. 2019. Ethiopia Mini Demographic and Health Survey 2019: Key indicators. Rockville, Maryland, USA: Ethiopian Public Health Institute and ICF.

240 Ibid.

241 Ibid.

242 Ibid.

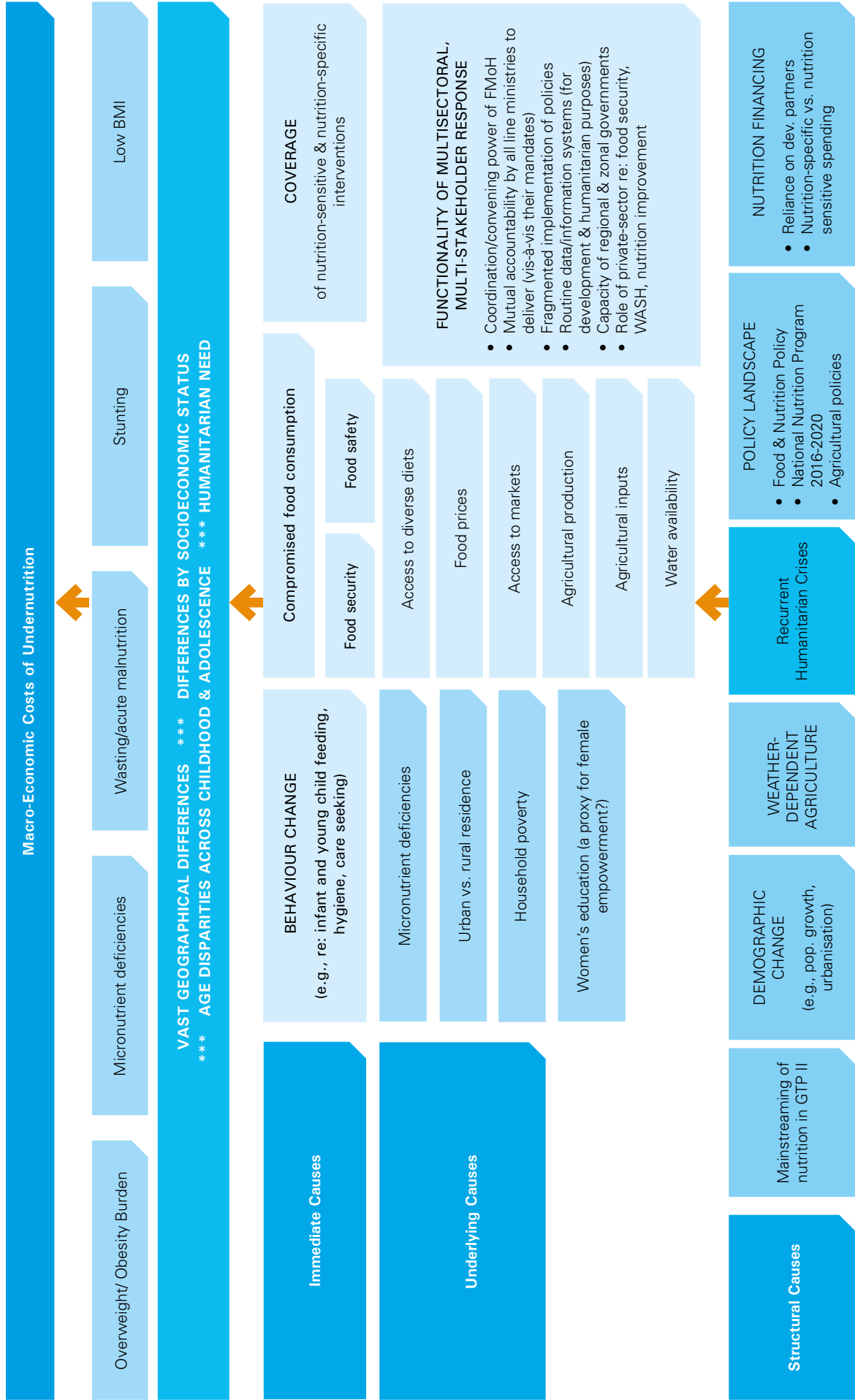
243 SPRI Global. 2019. Trends of Change in Gender Equality in Ethiopia (Policy Brief).

244 Central Statistical Agency and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: Central Statistical Agency and ICF.

245 National Disaster Risk Management Commission, Humanitarian Country Team and partners. 2019. Humanitarian Needs Overview.

246 Humanitarian and Disaster Resilience Plan Mid-Year Review, 2018, p. 26.

Figure 27. Causal pathway for key drivers of shortfalls and inequities related to nutrition



2.5.3. Drivers of identified shortfalls and differentials

Figure 27 depicts some of the key causes of identified shortfalls and differentials related to nutrition. Malnutrition is not just related to food intake. There are structural issues related to policy, financing and hazards (e.g., extreme weather events); underlying factors that speak to the broader issue of food systems and the functionality of multi-sectoral nutrition efforts; and immediate causes such as behaviours (e.g., related to hygiene, infant and young child feeding) and the coverage of both nutrition-specific and nutrition-sensitive interventions and services.

Further attention is required on the inter-play between drivers. For example, infant and young child feeding practices are an important aspect of nutrition improvement. Factors such as household poverty and lack of purchasing power at the household level on the demand side, and poor market availability of diverse foods on the supply side, limit the ability of mothers and/or caregivers to adopt age-appropriate complementary feeding practices.²⁴⁷

2.5.4. Sector-specific recommendations

1. In tackling child malnutrition in all its forms, formulate a food systems approach that is tailored to highland versus lowland settings and urban versus rural settings. The approach should leverage and/or enhance multi-sectoral, multi-stakeholder platforms at both federal and regional levels to ensure coherence and coordination across stakeholders (public, private, CSO, agriculture, WASH) that are addressing different aspects of the food system in specific settings.
2. To strengthen transparency and accountability in nutrition action, invest in: (a) greater nutrition integration/ mainstreaming in sector-specific

information systems (Health Management Information System) and surveillance; and (b) tracking sectoral spending on nutrition-specific and nutrition-sensitive interventions/programmes.

3. In light of increasing urbanization, formulate a pre-emptive strategy to thwart the rising overweight/obesity burden in women of reproductive age and their children.
4. Design and implement behaviour change strategies that account for factors in the enabling environment (market availability of nutritious foods). This will require cooperation between different sectors and actors (health extension workers, CSOs, agriculture sector, private sector).

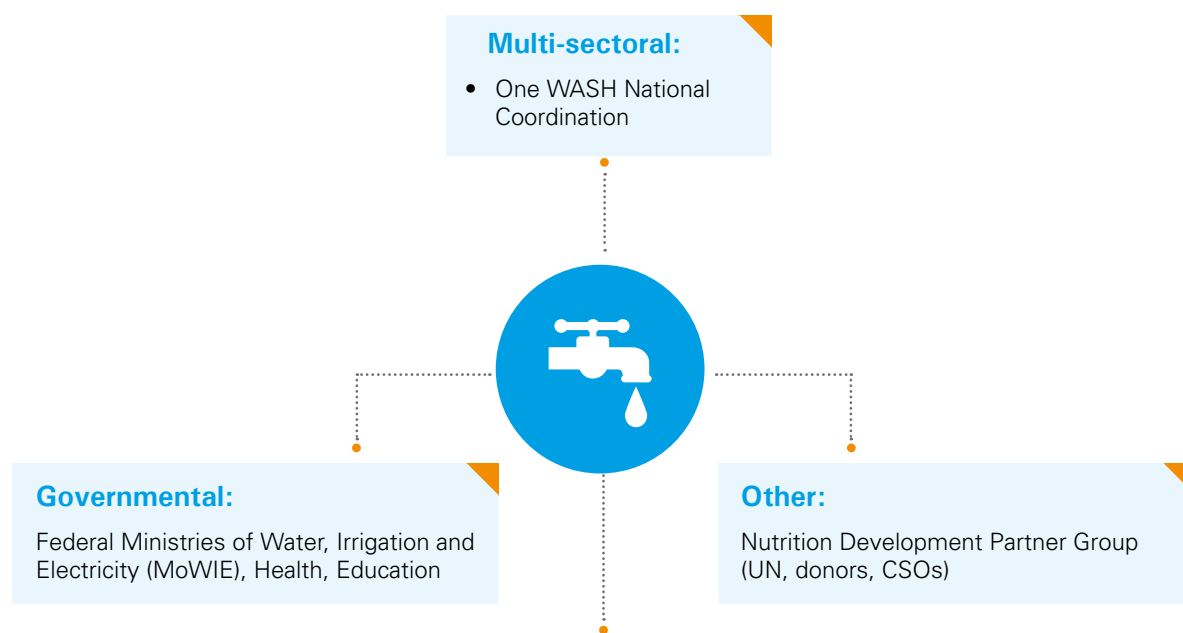
2.6. WASH

WASH is a crosscutting issue that impacts the lives of children and women in many ways. Ethiopia has enjoyed some WASH-related successes in recent years, for example achieving the Millennium Development Goal related to water by 2015. However, there has been a global elevation of WASH standards, with corresponding WASH-related indicators to monitor progress. Access to improved sanitation and sources of drinking water is necessary, but insufficient. Greater attention must now be paid to quality, as well as the persistent urban-rural divide and lowland-highland divide with respect to all aspects of WASH.



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247 UNICEF Eastern and Southern Africa Regional Office and Johns Hopkins Bloomberg School of Public Health. 2019. 'Complementary Feeding Landscape Analysis' (draft).

Figure 28. Stakeholder and policy landscape related to WASH**KEY ENTITIES AND STRUCTURES IN THE CURRENT WASH LANDSCAPE****THE CURRENT POLICY AND LEGAL LANDSCAPE RELATED TO WASH****For the General Population:**

- One WASH National Programme (OWNP)
- Integrated Urban Sanitation & Hygiene Strategy and Implementation Guidelines
- Water Sector Development Framework

Specifically related to Children and/or Women:

- Baby and Mother WASH Implementation Guideline (2017)

2.6.1. Policy and stakeholder landscapes

Figure 28 depicts key actors operating in Ethiopia's WASH arena.

2.6.2. Levels, trends and differentials in key indicators

From an equity perspective, improved WASH is an important prerequisite for levelling the playing field in terms of: gender disparities (reducing women's and girls' water collection responsibilities); lagging outcomes observed for pastoralists, whose mobility is often predicated on the search for water; and urban poor and rural populations that must contend with a higher burden of water-borne illnesses and malnutrition due to sub-par WASH

conditions. Children understand the importance of WASH (**Box 9**).

SDG indicator 6.2, "Proportion of population using safely managed sanitation services", reflects higher WASH standards than identified in the Millennium Development Goals.²⁴⁸ Based on the 2019 Joint Monitoring Programme (JMP) report, only 11 per cent of the population of Ethiopia is using safely managed drinking water, a minimal increase since 2010 when the estimate was 8 per cent.²⁴⁹ The rural-urban divide is vast: 5 per cent and 38 per cent, respectively. A 2017 study on drinking water quality in Ethiopia

248 JMP. 2017. WASH in the 2030 Agenda. New Global Indicators for Drinking Water, Sanitation and Hygiene, p. 5.

249 UNICEF and WHO. 2019. Progress on Household Drinking Water, Sanitation and Hygiene 2000-2017: Special focus on inequalities.

VOICES OF CHILDREN AND ADOLESCENTS

'...if we have water, we have everything...' (Oromia, Fentale, Haro Kersa, FGD with children)

Taken from UNICEF Ethiopia-commissioned research: Oxford Policy Management and the Horn Economic and Social Policy Institute (2018) *Generation El Niño: Long-term impacts on children's well-being: Final Report*. UNICEF: Ethiopia Country Office



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documented a similarly low national rate of safely managed drinking water coverage (13 per cent), as well as a similar rural-urban disparity (5 per cent in rural and 37 per cent in urban settings).²⁵⁰

Despite a major shortfall in population access to safely managed drinking water, **Figure 29** shows that tremendous strides were made between 2000 and 2017 in reducing the proportion of the population that relies on unimproved drinking water sources, such as unprotected dug wells, unprotected springs, carts with small tanks/drums, tanker trucks and surface water.

The 2016 EDHS also documents a gender element to accessing improved drinking water. For rural households, adult women and girls under 15 years are mainly responsible for collecting drinking water (for 68.2 per cent and 12.5 per cent of households, respectively).²⁵¹ By contrast, in urban households only 16.6 per cent of women and 1.9 per cent of girls under 15 years collect household drinking water.

Like the SDG water indicator, the SDG sanitation indicator reflects a more-stringent WASH standard: safely managed sanitation services. This entails use of an improved sanitation facility that is not shared with other households and where excreta are safely disposed in situ or transported and treated offsite. Only 4 per cent of the rural population has access to this standard of sanitation. The 2019 JMP report also shows a large socioeconomic divide, with 21 per cent of households in the highest wealth quintile and 5 per cent of households in the lowest wealth quintile having access to improved sanitation.²⁵²

An analysis of different deprivations in multi-dimensional child poverty shows that, since 2011, there have been significant improvements in access to safe drinking water. However, the percentage of children deprived of safe drinking water is still high (59 per cent of children under 5 years; 56 per cent of 5- to 17-year-olds).²⁵³ Children living in rural areas are much more deprived of safe drinking water than their urban counterparts (63 per cent and 14 per cent, respectively).

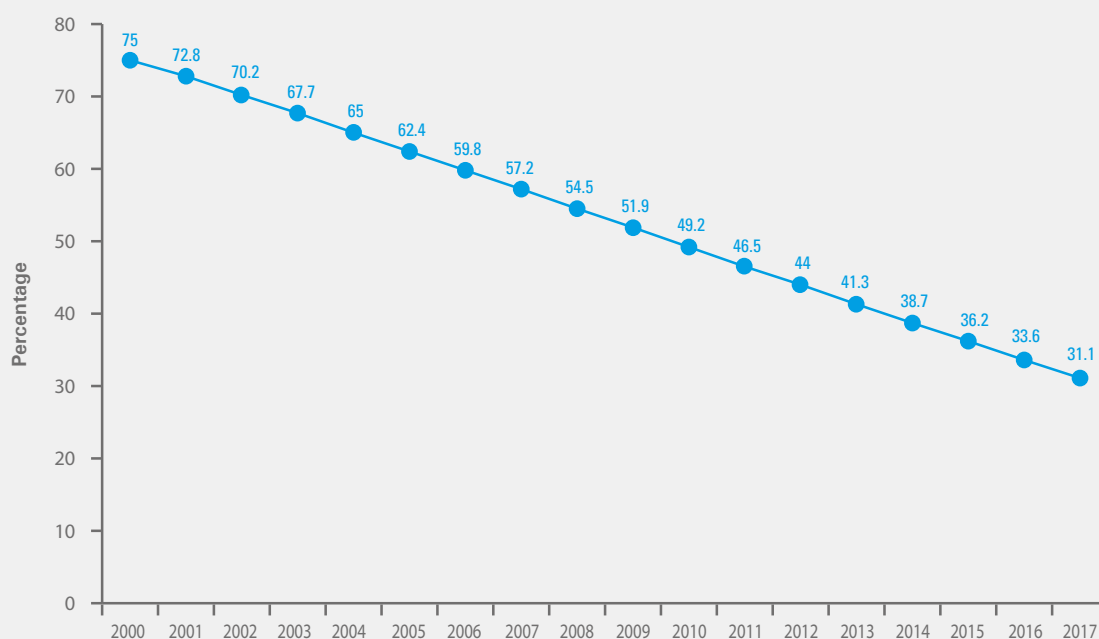
Shortfalls and inequities are even more striking with respect to sanitation. Deprivations in housing and sanitation are

250 Central Statistical Agency, *Drinking Water Quality in Ethiopia: Results from the 2016 Ethiopia Socioeconomic Survey, 2017*, p. 38. This study uses the JMP methodology, however the JMP uses multiple data sources for each sub-indicator to determine the official coverage. Therefore, the estimates "might not carry through to the formal SDG estimate". Ibid. p. 38 and 39.

251 Central Statistical Agency and ICF. 2016. *Ethiopia Demographic and Health Survey 2016*. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: Central Statistical Agency and ICF. Table 2.1.

252 UNICEF and WHO. 2019. *Progress on Household Drinking Water, Sanitation and Hygiene 2000-2017: Special focus on inequalities*.

253 Central Statistical Agency and UNICEF Ethiopia. 2018. *Multi-dimensional Child Deprivation in Ethiopia*.

Figure 29. Proportion of population using contaminated water

Note: Contaminated water includes unimproved and surface water.

Source: WHO/UNICEF Joint Monitoring Programme <https://washdata.org/monitoring/schools/country-files,2000-2017>.

the largest contributors to multi-dimensional child deprivation in Ethiopia. Among all children, the rate of deprivation of this basic right is 89 per cent, with children in rural areas being much more deprived than children in urban areas (94 per cent and 53 per cent, respectively).

Hygiene remains a priority issue in Ethiopia, both in emergency and non-emergency settings. For example, acute watery diarrhoea outbreaks signal diminished WASH conditions.²⁵⁴ In 2018, there were 3,357 acute watery diarrhoea cases reported in Afar, Oromia, Somali, Tigray and Dire Dawa.²⁵⁵ Notably, while the actual number of reported cases in 2018 was far lower than in 2017, a greater number of woredas were affected by cases in 2018.²⁵⁶

JMP data from 2017 indicate that hygiene must feature more prominently as a strategic priority in Ethiopia's WASH agenda. Annual

JMP estimates since 2007 show that there has been negligible change in the rate of hand washing over the past decade.²⁵⁷ Only 8 per cent of the population has access to a hand-washing facility with water and soap, according to the latest JMP report.²⁵⁸ Although there is a nationwide shortfall with respect to the magnitude of optimal hand-washing practices, there is a clear urban-rural divide, with 23 per cent of the urban population and 4 per cent of the rural population having access to a hand-washing facility with water and soap.²⁵⁹

However, there have been positive shifts in the promotion of other WASH-related practices. For example, FMoH adopted the Community-led Total Sanitation and Hygiene (CLTSH) approach in 2011, which it rolled out nationally via the Health Extension Programme. Although there was no baseline assessment, a 2015/2016 CLTSH survey spanning eight of Ethiopia's regions documented an open-defecation rate

254 National Disaster Risk Management Commission, Humanitarian Country Team and partners. 2019. Humanitarian Needs Overview.

255 National Disaster Risk Management Commission, Humanitarian Country Team and partners. 2019. Humanitarian Needs Overview.

256 Ibid.

257 JMP. 2017. Updated Estimates on Handwashing.

258 UNICEF and WHO. 2019. Progress on Household Drinking Water, Sanitation and Hygiene 2000-2017: Special focus on inequalities.

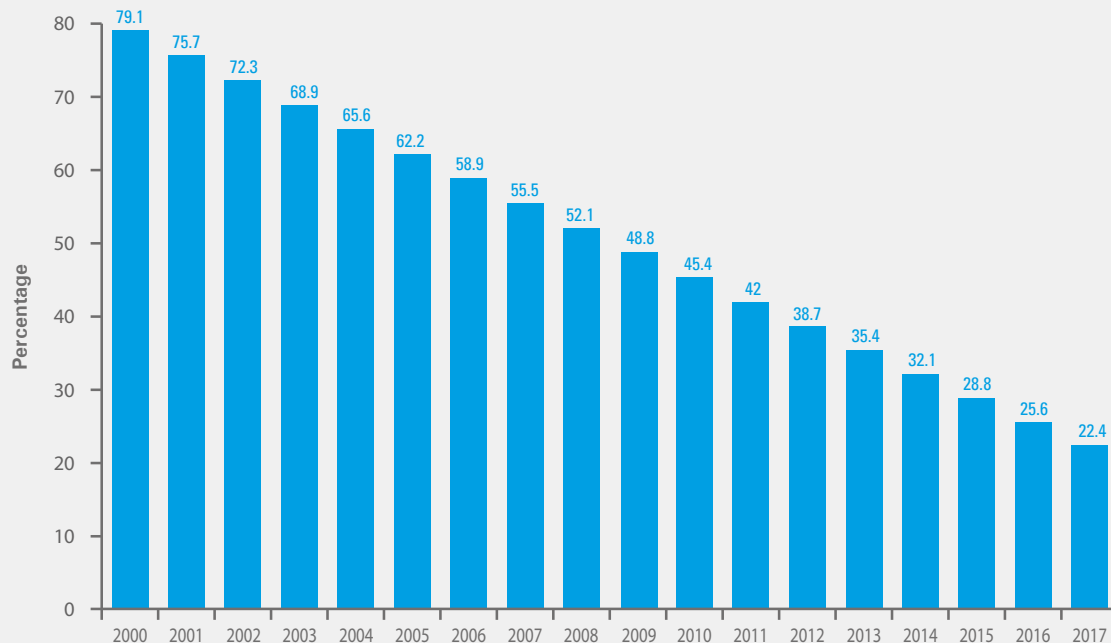
259 Ibid.

of 32 per cent.²⁶⁰ A 2019 JMP report states that over half of Ethiopia's population has stopped practicing open defecation.²⁶¹ **Figure 30** shows that there were major strides in reducing the rate of open defecation between 2000 and 2017, according to JMP data. **Figure 31** is a map of open-defecation-free status by woreda, based on 2018 data from the National Sanitation Micro Plan Dataset. As shown in the map, no woredas have achieved 100 per cent open-defecation-free status, although several are close (as depicted by a green colour). An outcome evaluation of CLTSH efforts between 2012 and 2015 found tremendous regional variation, with the overwhelming majority of households in Afar (88 per cent) and Gambella (71 per cent) still relying on open fields for

defecation.²⁶² In contrast, the practice is minimal in Benishangul-Gumuz (0.5 per cent) and SNNP (4.5 per cent).²⁶³

There are data gaps related to institutional WASH. According to Ethiopia's One WASH National Programme Phase II document (November 2018), schools often have inadequate water and sanitation facilities. In 2015, 11 per cent of primary schools had appropriate water facilities and 3.2 per cent had all WASH facilities. The same document provided estimates that as many as 80 per cent of health facilities are without adequate water and sanitation facilities, and 97 per cent are without hand-washing facilities. **Figure 32** is a graphical depiction of WASH coverage among health centers.

Figure 30. People practicing open defecation



Source: WHO/UNICEF Joint Monitoring Programme <https://washdata.org/monitoring/schools/country-files,2000-2017>.

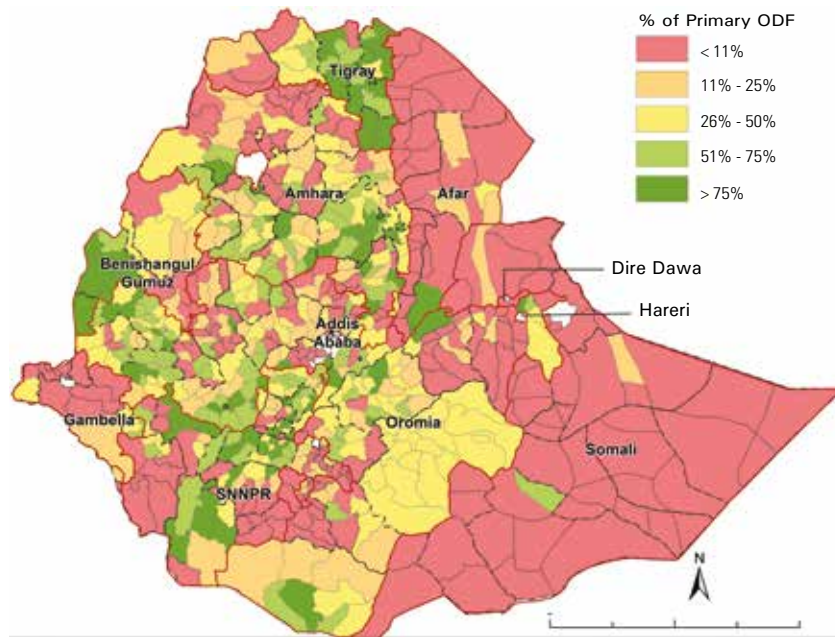
260 UNICEF. 2017. Progress on CLTSH in Ethiopia: Findings from a national review. WASH Field Note FN/01/2017. Retrieved from: <https://www.unicef.org/ethiopia/media/176/file>

261 UNICEF and WHO. 2019. Progress on Household Drinking Water, Sanitation and Hygiene 2000-2017: Special focus on inequalities.

262 BDS-Center for Development Research. n.d. Outcome Evaluation of CLTSH Program in Ethiopia from 2012-2015: Final Report. Retrieved from: https://www.unicef.org/evaldatabase/files/Final_Report_of_CLTSH_Outcome_Evaluation-Designed_Ethiopia_2016-012.pdf.

263 UNICEF. 2017. Progress on CLTSH in Ethiopia: Findings from a national review. WASH Field Note FN/01/2017. Retrieved from: <https://www.unicef.org/ethiopia/media/176/file>

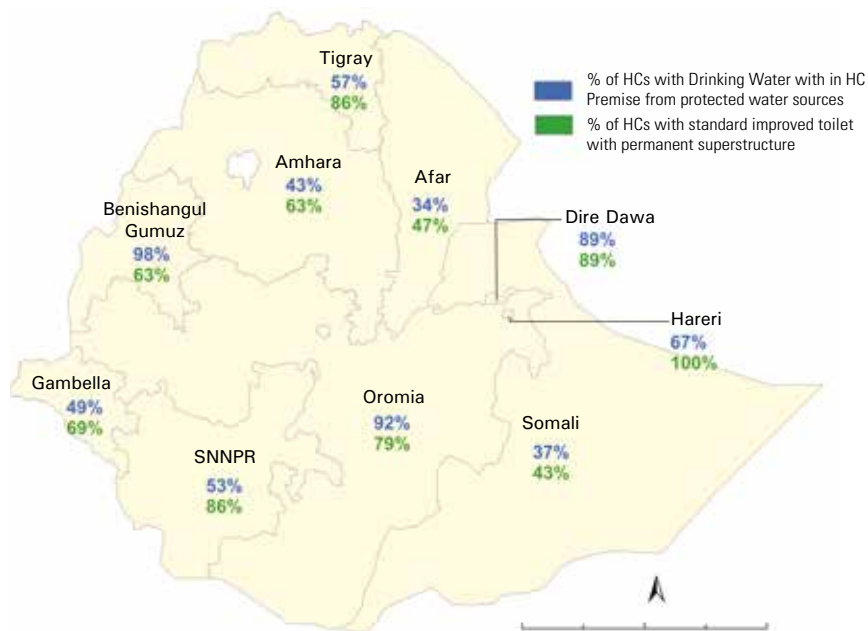
Figure 31. Open defecation by woreda



Note: This is not a census and it relies on the subjective judgement of HEWs.

Source: National Sanitation Micro Plan Dataset, which was compiled by HEWs in regions in 2018 and brought together at national level by FMoH and UNICEF.

Figure 32. WASH coverage in health centre per region



Source: National Sanitation Micro Plan Dataset, which was compiled by HEWs in regions in 2018 and brought together at national level by FMoH and UNICEF.

Menstrual hygiene management in schools contributes to gender equality in multiple domains, for example education and health, as well as WASH. It entails a comprehensive set of interventions that address commodity needs (sanitary pads, analgesics, waste disposal/waste management supplies or equipment) and infrastructure needs (upgraded/rehabilitated toilet facilities). Both males and females need to have knowledge and attitudes to create an enabling environment around menstrual hygiene management. In 2016, FMoH developed a menstrual hygiene management policy and implementation guidelines, in collaboration with other ministries and with support from UNICEF and partner agencies.²⁶⁴ Menstrual hygiene management promotion and gender-sensitive WASH construction is now part of Ethiopia's One WASH Programme.²⁶⁵

The WASH sector has made strides with respect to Baby WASH—an intervention approach that triggers hygiene behaviour change with a focus on pregnant women, babies and children under 3 years. UNICEF has piloted Baby WASH programmes in SNNP and Amhara, engaging trained health extension workers to support communities in behaviour change related to hygiene practices that can improve ECD.²⁶⁶

In light of Ethiopia's vulnerability to climate-induced hazards, climate-resilient WASH is receiving greater attention in the WASH arena. This not only addresses ensuring safe and accessible WASH infrastructure that can withstand climate-induced hazards, it also has implications for reducing women's and girls' vulnerability to gender-based violence in humanitarian settings. The physical security of women and girls is often at risk when dealing with water insecurity in camps and temporary settlements.²⁶⁷ In 2014, UNICEF

and the Global Water Partnership developed the Strategic Framework for WASH Climate-Resilient Development.²⁶⁸ Ethiopia's Federal Ministry of Water, Irrigation and Electricity developed the Climate Resilience Strategy for Water and Energy (2015), the Climate-Resilient Water Safety Plan Implementation Guidelines for Community-Managed Rural Drinking Water Supplies (2015), and has conducted several national and regional training events to support pilot efforts related to climate-resilient water safety planning. A WHO/DFID examination of climate change, health and WASH in Ethiopia highlighted the importance of community engagement and outreach to foster grassroots ownership for sustainable, climate-resilient WASH programmes and mainstreaming of climate-resilient water safety planning into planning and funding cycles, given the resource requirements of climate-resilient WASH infrastructure.²⁶⁹ Given the disproportionate impacts of climate change on women and children,²⁷⁰ woman- and child-centred approaches to climate-resilient WASH are highly important.

2.6.3. Drivers of identified shortfalls and differentials

As mentioned earlier in the report, public spending on WASH is <1 per cent, far lower than spending for other social sectors. **Figure 33** depicts various factors that drive identified shortfalls and differentials related to WASH.

There is still a knowledge-practice gap that must be bridged for all WASH behaviours, including menstrual hygiene management. Although investments are being made in WASH infrastructure expansion, the availability of improved WASH facilities is an issue in both community and institutional settings (e.g., schools, health facilities). In addition, uptake of some WASH behaviours is commodity-dependent, and access to essential

264 Federal Ministry of Health/Federal Democratic Republic of Ethiopia. 2017. Menstrual Hygiene Management in Ethiopia. An Intersectional Issue: Policy and implementation guideline.

265 Ibid.

266 UNICEF ECO. 2018. Baby WASH: Increasing communities' awareness through health extension workers.

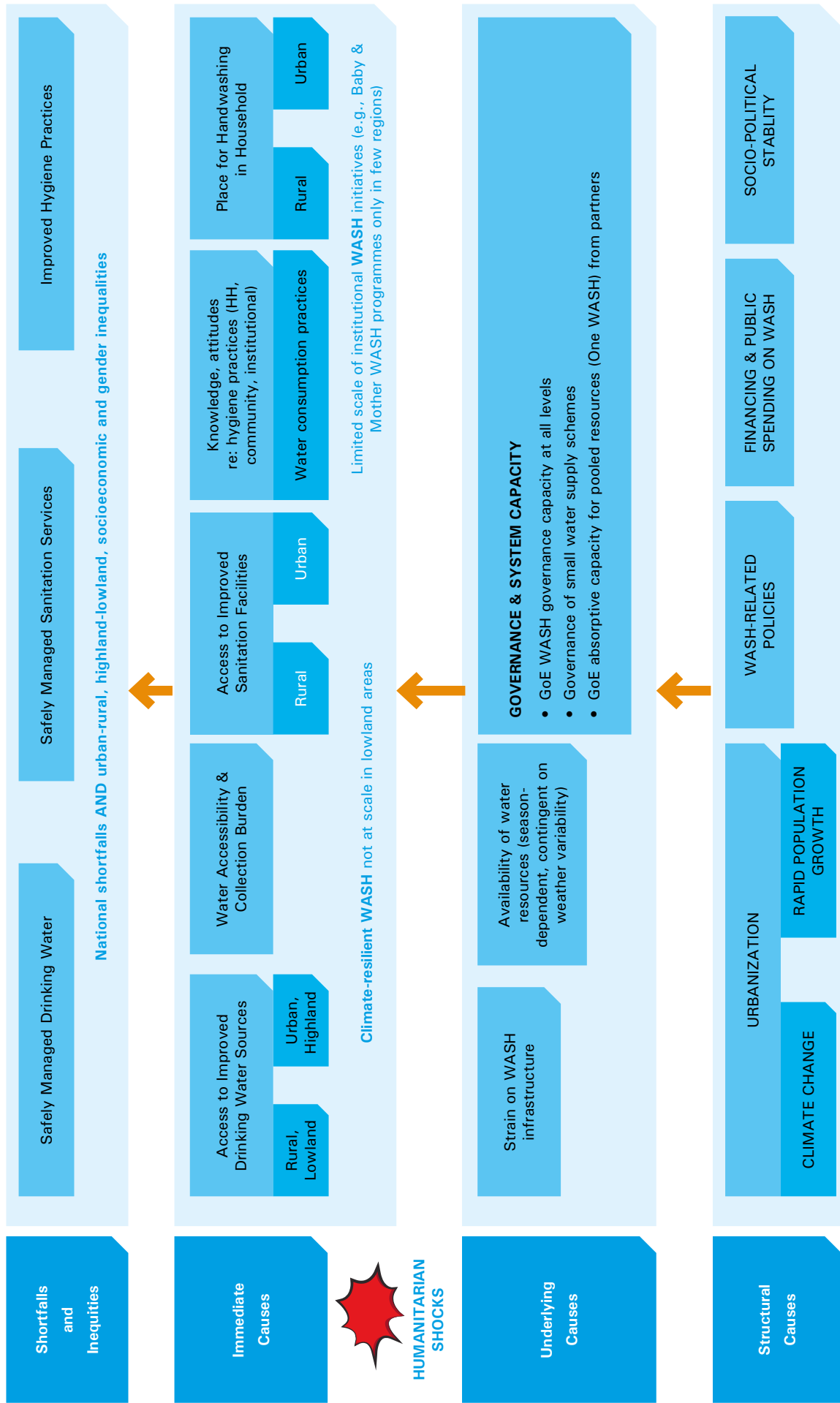
267 Committee on the Elimination of Discrimination against Women. 2018. General recommendation No. 37 (2018) on the gender-related dimensions of disaster risk reduction in the context of climate change. Document No. CEDAW/C/GC/37.

268 Global Water Partnership and UNICEF. 2014. WASH Climate Resilient Development: Strategic framework.

269 World Health Organization. 2018. Ethiopia: Climate change, health and WASH. Retrieved from: <https://www.who.int/globalchange/resources/wash-toolkit/ethiopia-climate-change-wash.PDF?ua=1>.

270 UNICEF. 2015. Unless We Act Now: The impact of climate change on children. Retrieved from: https://www.unicef.org/publications/files/Unless_we_act_now_The_impact_of_climate_change_on_children.pdf

Figure 33. Causal pathway for identified shortfalls and inequities related to WASH



commodities and supplies are particularly important in addressing equity issues under the WASH programme. For example, some girls/women have limited access to sanitary pads. In July 2018, the Ethiopia Standards Agency set national standards for disposable and reusable sanitary pads, also setting the stage for domestic production of the commodity.²⁷¹ Ensuring actual implementation of the standards is critical to facilitating behaviour change. As with other sectors, there are also practical considerations related to WASH, such as the participation of women in management and decision making related to water supply and other WASH issues.

2.6.4. Sector-specific recommendations

1. Drawing on data from other sectors or programme areas, such as Education, Health and Nutrition, identify and address children's access barriers to essential WASH commodities, for example, adolescent girls' access to menstrual hygiene-related commodities, and prioritizing implementation in regions/geographical locations with lagging performance on key indicators of child well-being (low school attendance, high rates of chronic malnutrition).
2. Develop and test a gender-sensitive package of WASH interventions that addresses and measures changes in women's and girls' time spent collecting drinking water (humanitarian and non-humanitarian settings), access to and use of gender-sensitive WASH facilities (e.g., in schools), access to and use of WASH commodities (e.g., sanitary pads, waste disposal tools for used sanitary pads) and selected outcomes that can be affected by the above (e.g., exposure to gender-based violence, school attendance). The intervention package should include explicit measures to promote women's involvement in WASH management and decision making.
3. Redouble efforts related to climate-resilient WASH to narrow the divide between lowlands and highlands, and contribute to narrowing the divide between rural and urban areas, in WASH. Given the impacts of climate change on women and children, those efforts should be child- and woman-centred.
4. Through evidence-informed, contextually appropriate behaviour change interventions tailored to urban versus rural and lowland versus highland settings, promote optimal hygiene practices, tackling underlying factors that are barriers and bottlenecks to hygiene-related behaviour change.
5. Leveraging learning and evidence from Baby WASH pilots, replicate the Baby WASH model in geographical locations with high incidences of diarrhoeal disease in children and/or high rates of malnutrition, including parts of the country that have been hotspots for acute watery diarrhoea outbreaks.

2.7. Adolescents

The original CRC does not draw a distinction between 'children' and 'adolescents'. General Comment 20 (issued in 2016) does, however, specifically address the implementation of the rights of the child during adolescence.

There is a notable paucity of policy instruments that are specific to adolescents. Some national instruments and documents include explicit priorities related to adolescents and youth. For example, Pillar 8 of GTP II aims to "promote women and youth empowerment, ensure their participation in the development process and enable them to equitably benefit from the outcomes of development".²⁷²

According to the UN, adolescents are defined as females and males aged 10-19 years.²⁷³ As described in earlier chapters, adolescents are a key demographic group in Ethiopia. Their holistic development and participation are central to sustained growth and the

271 Ethiopian Standards Agency, Sanitary Pads (Specification) Part 1: Disposable, 2018, (File No. ES 6345:2018) pp. 1-18 and Ethiopian Standards Agency, Sanitary Pads (Specification) Part 2: Reusable, 2018, (File No. ES 6346:2018), pp. 1-17.

272 GTP II, pp. 81 and 208-210.

273 United Nations Population Fund. n.d. Adolescent and Youth Demographics: A brief overview. <https://www.unfpa.org/sites/default/files/resource-pdf/One%20pager%20on%20youth%20demographics%20GF.pdf> Accessed 29 May 2019.

development of the entire nation. However, both adolescent females and males constitute a highly vulnerable sub-population in Ethiopia.

The SDGs address issues that can positively impact adolescents, however there are also special global initiatives to redouble investment in adolescents, for example via Generation Unlimited and the UN Youth Strategy, 'Youth 2030'.²⁷⁴

2.7.1. Policy and stakeholder landscape

As depicted in **Figure 34**, there are numerous policies, strategies and plans that are relevant to adolescents. There are also multiple actors within the landscape but no cross-sectoral, multi-stakeholder platform to coordinate and harmonize efforts, and synthesize and examine evidence on the various dimensions of adolescent development and participation.

A 2017 landscape analysis of adolescent health and nutrition highlighted that adolescents are often mentioned as an important target group, but rarely targeted in a holistic manner. Instead, they are the focus of siloed efforts, for example focusing on sexual and reproductive health.²⁷⁵

2.7.2. Levels, trends and differentials in key indicators

In Ethiopia, gender inequalities exist across people's life spans. However, the gender divide is particularly prominent starting in adolescence.²⁷⁶ As observed in previous Situation Analyses, there is also tremendous regional variation in available data on adolescents (Annex 1).

ADOLESCENT FERTILITY—The current HSTP aims to reduce the adolescent/teenage pregnancy rate of 12 per cent to 3 per cent

by 2020.²⁷⁷ According to the 2016 EDHS, 6 per cent of females aged 15-19 and less than 1 per cent of males aged 15-19 had had intercourse before the age of 15.²⁷⁸ Since 2000, there has only been a slight decrease in the percentage of teenagers who have given birth or are pregnant (16 per cent in 2000, compared with 12 per cent to 13 per cent in 2016).²⁷⁹ Teenagers in rural areas are much more likely than their urban counterparts to have begun childbearing (15 per cent and 5 per cent, respectively). There is also a very strong correlation with household wealth quintile: 24 per cent of teenagers in the lowest wealth quintile, compared with 6 per cent of teenagers in the highest wealth quintile, have begun childbearing.²⁸⁰ Teenage pregnancy can have multi-generational effects. For example, the Young Lives longitudinal study showed that a child born to a stunted adolescent mother had a 15-percentage point increased chance of being stunted.²⁸¹

ADOLESCENT HEALTH—The main orientation of adolescent health-related efforts to date has been on sexual and reproductive health. FMOH developed a national strategy with a minimum service package for scaling up adolescent and youth reproductive health services. The coverage and quality of adolescent-friendly health services is extremely limited. However, according to the past three rounds of the EDHS, there have only been minimal increases in modern contraceptive use among sexually active 15- to 19-year-old women (4.5 per cent in 2005 to 7.4 per cent in 2016).^{282,283} Among

274 <http://www.genunlimited.org/> and <https://www.un.org/development/desa/youth/>

275 Truebwasser, Ursula. 2017. Landscape Analysis of Adolescent Health and Nutrition in Ethiopia, September 2017.

276 CRC, General Comment No. 20 (2016) on the implementation of the rights of the child during adolescence (CRC/C/GC/20).

277 Federal Ministry of Health/Federal Democratic Republic of Ethiopia. 2015. Health Sector Transformation Plan 2015/16-2019/20 (2008-2012 EFY).

278 Central Statistical Agency and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: Central Statistical Agency and ICF. Table 12.14

279 Ibid. p. 81.

280 Ibid. p. 82.

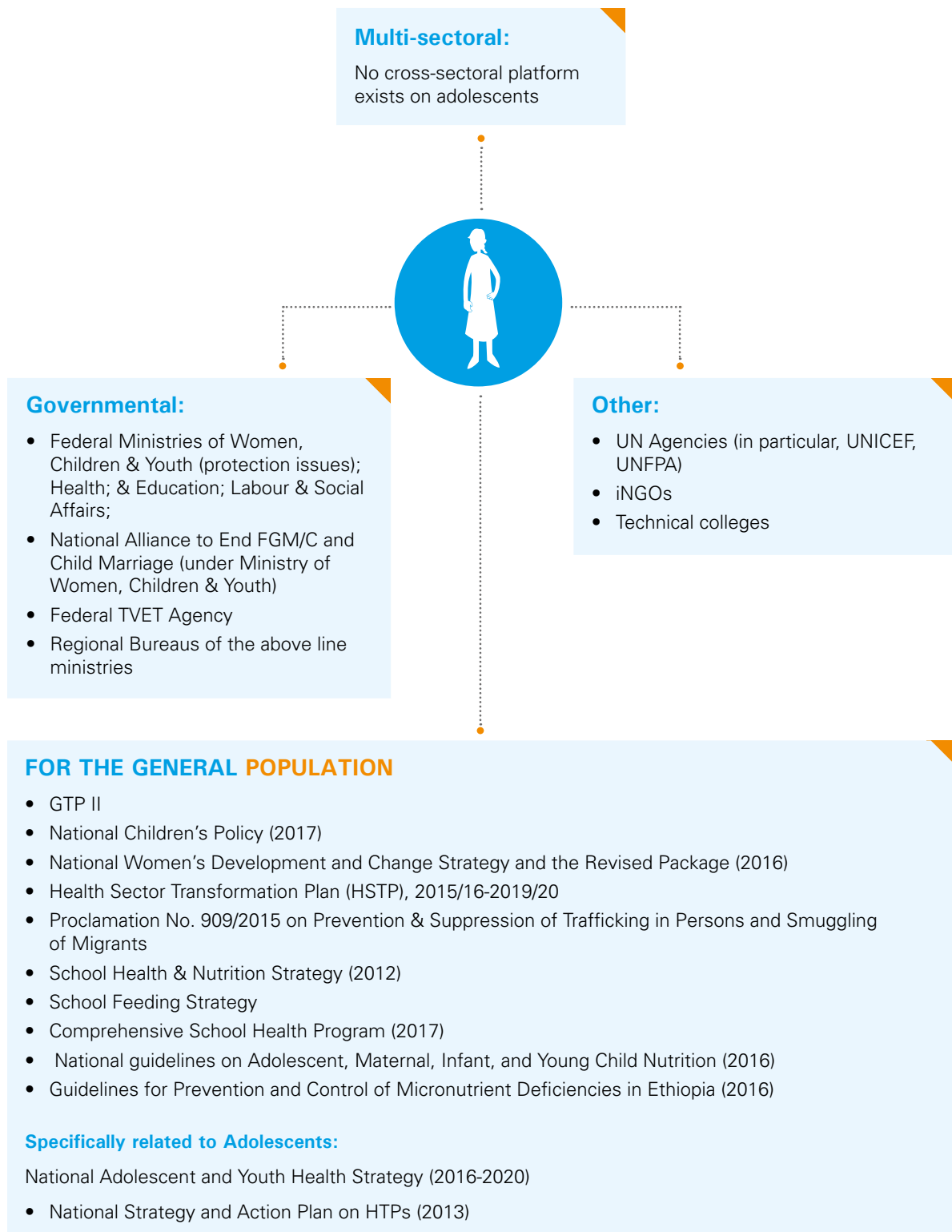
281 Benny, L. et al. 2017. Maternal Under-nutrition and Childbearing in Adolescence and Offspring Growth and Development in Low- and Middle-Income Countries: Is adolescence a critical window for interventions against stunting? Working Paper 165.

282 Central Statistical Agency and ORC Macro. 2006. Ethiopia Demographic and Health Survey 2005. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ORC Macro.

283 Central Statistical Agency and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: Central Statistical Agency and ICF.

Figure 34. Policy and stakeholder landscape related to adolescents

KEY ENTITIES AND STRUCTURES IN THE CURRENT LANDSCAPE SUPPORTING ADOLESCENTS



currently married 15- to 19-year-olds, modern family planning use increased from 31.8 per cent in 2016 to 36.5 per cent in 2019.^{284,285} Other aspects of adolescent health, such as mental health, are largely overlooked. However, findings from the Gender and Adolescence: Global Evidence (GAGE) longitudinal study (2015-2024) indicate higher levels of mental distress in adolescents from Afar, urban adolescents and older adolescent girls than among other adolescents.²⁸⁶ Qualitative data from the same study attribute some of the anxiety and depression experienced by adolescent females to sexual harassment, risks of sexual violence and child marriage, which is associated with early pregnancy (and also associated with increased vulnerability of teen mothers and their offspring).

ADOLESCENT NUTRITIONAL STATUS—

Adolescence is a critical window or opportunity for interventions to improve nutritional status. As noted in the chapter on nutrition, there are myriad nutrition-related strategies, guidelines and plans that include adolescents as one of many target population groups. For example, the National Guidelines for Prevention and Control of Micronutrient Deficiencies in Ethiopia (2016) call for weekly iron and folate supplementation for 10- to 19-year-olds. Nonetheless, among females aged 15-19 years, 29 per cent are 'thin' (BMI below 18.5), 3.4 per cent are overweight or obese, and 19.9 per cent are anaemic.²⁸⁷ Corresponding rates of thinness, overweight/obesity and anaemia among males aged 15-19 are 59 per cent, 0.6 per cent and 18.2 per cent, respectively.²⁸⁸ The Young Lives longitudinal study showed that adolescence is still a critical window of opportunity for nutrition intervention,

with the potential for catch-up growth in early adolescence (age 12-15 years) among Ethiopian females.²⁸⁹ However, there is a paucity of programmes that explicitly address adolescent nutrition, even though adolescent nutrition is reflected in national strategies and plans.²⁹⁰

Findings from a recent analysis of gender equality showed that a significantly larger proportion of adolescent males are under-nourished than adolescent females (59 per cent and 28 per cent, respectively).²⁹¹ Thus, both adolescent boys and girls must be targeted with nutrition interventions.

HIV IN ADOLESCENTS—With a general population prevalence of 0.9 per cent, Ethiopia has a lower HIV burden than other African countries.²⁹² However, due to Ethiopia's large population size, this seemingly low HIV prevalence equates to large absolute numbers of people infected with HIV. Data on HIV in adolescents is sparse, although available data suggest that urban girls who are in-migrants have a significantly higher HIV prevalence



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284 Ethiopian Public Health Institute and ICF. 2019. Ethiopia Mini Demographic and Health Survey 2019: Key indicators. Rockville, Maryland, USA: Ethiopian Public Health Institute and ICF.

285 Central Statistical Agency and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: Central Statistical Agency and ICF.

286 Jones, N., Presler-Marshall, E., Hicks, J., Baird, S., Devonald, M., Neumeister, E., Yadete, W. and Kebede, M. 2019. Adolescent Psychosocial Well-being and Voice and Agency in Ethiopia: A report on GAGE Ethiopia baseline findings. London: Gender and Adolescence: Global Evidence.

287 Central Statistical Agency and ICF. Tables 11.10.1 and 11.11.1.

288 Ibid. Tables 11.10.2 and 11.11.2.

289 Benny, L. et al. 2017. Maternal Under-nutrition and Childbearing in Adolescence and Offspring Growth and Development in Low- and Middle-Income Countries: Is adolescence a critical window for interventions against stunting? Working Paper 165.

290 Truebwasser, Ursula. 2017. Landscape Analysis of Adolescent Health and Nutrition in Ethiopia, September 2017.

291 SPRI Global. 2019. Trends of Change in Gender Equality in Ethiopia (Policy Brief).

292 Ethiopia Demographic and Health Surveys 2011 and 2016.

than girls who have always lived in the urban centre.²⁹³

The 2016 EDHS highlighted that there is still a knowledge gap among adolescents around HIV prevention, with only 51 per cent of females aged 15-19 and 66 per cent of males aged 15-19 knowing that both using condoms and limiting sexual intercourse to one uninfected partner can reduce the risk of acquiring HIV.²⁹⁴ Only one quarter of females aged 15-19 and slightly more than one third of males aged 15-19 have comprehensive knowledge about HIV.²⁹⁵ Vulnerable girls are least knowledgeable about HIV and AIDS. For example, a 2017 study of girls across six regions/administrative areas of the country (Addis Ababa, Amhara, Dire Dawe, Harar, Oromia and Tigray) found that domestic workers and rural girls had the lowest levels of HIV knowledge (8 per cent and 10 per cent, respectively).²⁹⁶

Insights from the EDHS, HIV programmes and research on adolescent sexual and reproductive health underscore a need to link adolescents with accurate information related to sexuality, puberty and topics such as menstrual hygiene management.²⁹⁷ Equally important are the materials used to convey information in accurate and supportive terms.

SUBSTANCE ABUSE—Data on substance abuse among adolescents is limited. However, the 2016 EDHS documented no self-reported use of tobacco of any kind among females aged 15-19 years, while only zero to 4 per cent

of males aged 15-19 self-reported tobacco use.²⁹⁸ Alcohol consumption is more prevalent. Nationally, 3 out of 10 females aged 15-19 and almost 4 out of 10 males aged 15-19 reported ever drinking alcohol.²⁹⁹ Regional, youth-specific estimates are not available, however there are stark regional differences in the use of those substances among women and men of reproductive age, with Tigray, Amhara and Addis Ababa having far higher rates of use (62 per cent to 76 per cent among females and 71 per cent to 91 per cent among males) than the national average (35 per cent among women of reproductive age and 46 per cent among men of reproductive age).³⁰⁰

EDUCATIONAL ATTAINMENT—Secondary school attainment was examined in the chapter on education. However, it is important to underscore that the chasm between females and males vis-à-vis educational attainment is more prominent during adolescence than any other time in childhood. Adolescent development vis-à-vis education includes, but is not limited to, educational attainment. Efforts in Ethiopia to increase school enrolment and attendance, particularly for girls, are employing cross-sectoral approaches such as the menstrual hygiene management efforts described in the WASH chapter. As cited in the National Adolescent and Youth Strategy 2016-2020, an estimated 15 per cent of girls and young women have missed school because of menstruation.³⁰¹ One published study conducted in Amhara documented how the lack of basic commodities, such as sanitary napkins and single-sex bathrooms for menstruating girls can deter early adolescent girls from attending school.³⁰² The educational setting must be responsive to special needs that emerge during adolescence to create an enabling environment that attracts and retains adolescent females and males within the education system.

293 Erulkar, Annabel, Girmay Medhin and Lemi Negeri. 2017. *The Journey of Out-of-School Girls in Ethiopia: Examining migration, livelihoods and HIV*. Addis Ababa: Population Council.

294 Central Statistical Agency and ICF. 2016. *Ethiopia Demographic and Health Survey 2016*. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: Central Statistical Agency and ICF. Table 12.1.

295 2016 EDHS, Table 12.13. Comprehensive knowledge relates to prevention (consistent condom use during sexual intercourse, having just one uninfected partner), and myths and misconceptions (knowing that a healthy-looking person can have HIV, HIV transmission via mosquitoes).

296 Erulkar, Annabel, Girmay Medhin and Lemi Negeri. 2017. *The Journey of Out-of-School Girls in Ethiopia: Examining migration, livelihoods, and HIV*. Addis Ababa: Population Council.

297 Blake, S., Boone, M., Yenew Kassa, A. and Sommer, M. 2018. 'Teaching Girls About Puberty and Menstrual Hygiene Management in Rural Ethiopia: Findings from a pilot evaluation', *Journal of Adolescent Research*, 33(5), 623–646. <https://doi.org/10.1177/0743558417701246>

298 *Ibid.* Table 3.10.2

299 *Ibid.* Tables 3.12.1 and 3.12.2.

300 *Ibid.*

301 Ministry of Health/Federal Democratic Republic of Ethiopia. 2016. *National Adolescent and Youth Health Strategy*. (ORIGINAL SOURCE DATA: Tegegne et al., 2014).

302 Tegegne, Teketo and Sisay, Mitike. 2014. 'Menstrual Hygiene Management and School Absenteeism among Female Adolescent Students in Northeast Ethiopia', *BMC Public Health*, 14. 1118. [10.1186/1471-2458-14-1118](https://doi.org/10.1186/1471-2458-14-1118).

Adolescent development vis-à-vis education is also contingent on the quality of the education. According to a 2018 Multiple Overlapping Deprivation Analysis (MODA) study, deprivation in education among 15- to 17-year-olds is largely driven by illiteracy.³⁰³ In Ethiopia, just under two thirds of adolescent females (64 per cent) and over three quarters of adolescent males (79 per cent) are literate.³⁰⁴ Geographical and gender disparities in literacy highlight shortfalls in learning outcomes among females and males that can be attributed to the quality of education.³⁰⁵ More than 5 out of every 10 rural adolescents (53 per cent), and less than 2 out of every 10 urban adolescents (18 per cent), are illiterate. The illiteracy rate is the lowest in Addis Ababa (16 per cent) and the highest in Afar (72 per cent).

ACCESS TO INFORMATION—Access to information is a potential driver of adolescent development and participation. However, a recent MODA study found that 83 per cent of 15- to 17-year-olds in Ethiopia were deprived of information and participation.³⁰⁶ Weekly access to mass media—newspapers, television or radio—is extremely low. Seven out of every 10 adolescent females (69 per cent) and 6 out of every 10 adolescent males (62 per cent) have no weekly access to mass media.³⁰⁷

In the Internet age, there are other viable ways to access information. However, according to the 2016 EDHS, Internet usage is extremely low among adolescents, with only 6 per cent of adolescent females and 14 per cent of adolescent males using the Internet in the past 12 months.³⁰⁸

However, published research from Ethiopia suggest that social media is becoming increasingly prominent in young people's daily

lives, and that they ascribe recreational and social/relational benefits to social media use.³⁰⁹

LABOUR AND ECONOMIC

PARTICIPATION—A child labour study conducted in 2015 found that 65 per cent of 14- to 17-year-olds participated in economic activities.³¹⁰ Adolescent males are much more likely than adolescent females to engage in economic activities (78 per cent among 15- to 17-year-old males, and 51 per cent among 15- to 17-year-old females).³¹¹ According to the 2016 EDHS, 40 per cent of currently married 15- to 19-year-old females were employed in the 12 months preceding the survey. Too few married males were in the 15- to 19-year age group to calculate a corresponding figure for adolescent males.

Based on a set of criteria used to define 'child labour' (i.e., work that affects children's physical and mental development, exposes children to safety and health problems, affects their educational opportunities and school attendance, exposes them to working long hours with minimum payment, and is exploitative in nature and reflects an employee-employer relationship), the 2015 National Child Labour Survey found that 30.4 per cent of children aged 12-13 years and 31.1 per cent of children aged 14-17 years were involved in child labour.³¹² In contrast, 19.7 per cent of 5- to 11-year-olds were involved in child labour. Rural males aged 12-17 years had the highest rate of child labour (41 per cent).

Leveraging technology and mechanisms can facilitate youth economic participation. Personal ownership of a mobile phone is still far from optimal in Ethiopia (27.3 per cent among females aged 15-49 and 53.7 per cent among males aged 15-49).³¹³ Among 15- to

303 Central Statistical Agency and UNICEF Ethiopia. 2018. Multi-dimensional Child Deprivation in Ethiopia.

304 Central Statistical Agency and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: Central Statistical Agency and ICF. Table 3.3.2.

305 SPRI Global. 2019. Trends of Change in Gender Equality in Ethiopia (Policy Brief).

306 Ibid. p. 48.

307 Ibid. Tables 3.4.1 and 3.4.2

308 Ibid. Tables 3.5.1 and 3.5.2

309 Mulisa, F. and Getahun, D.A. 2018. 'Perceived Benefits and Risks of Social Media: Ethiopian secondary school students' perspectives', *Journal of Technology in Behavioural Science*, 3(4): 294. <https://doi.org/10.1007/s41347-018-0062-6>

310 Central Statistical Agency and International Labour Organization. 2018. Ethiopia National Child Labour Survey.

311 Ibid. Table 5.6

312 Ibid., Table 7.12

313 Central Statistical Agency and ICF. 2016. Ethiopia Demographic and Health Survey 2016.

19-year-olds, 29 per cent of females and 42 per cent of males personally own a mobile phone. Only 8 per cent of females and 10 per cent of males aged 15-19 use a bank account.

Various phenomena that affect adolescents are interrelated. For example, females who get married in childhood are less likely to be employed than females who are/were not child brides, and when they are employed, they are more likely to be engaged in unskilled occupations.³¹⁴ There is also limited but compelling evidence that girls who drop out of school are a sub-population on the move, often moving from rural areas to larger towns or cities where they pursue low-paying jobs, such as domestic work (earning an average of 495 ETB / US\$ 22 per month) and/or work in restaurants or cafés. They sometimes transition to higher-paying commercial sex work (earning an average of 3,524 ETB / US\$ 160 per month).

COMMUNITY PARTICIPATION—Adolescent participation requires multiple forums and entry points to give them the social and political space to be heard in the public sphere. A MODA study found that the extent of adolescent household and community participation (using participation in community conversations or events to expose them to family planning messages, as a proxy for community participation) has not improved in recent years. In fact, the same study documented an increase in this form of deprivation, from 69 per cent in 2011 to 76 per cent in 2016.³¹⁵

Recent research shows that, while conservative gender- and age-related social norms persist as possible factors that limit adolescent voice and agency within families and communities, Ethiopia's current state of political transformation is cultivating opportunities for greater adolescent agency, particularly via platforms such as schools and children's parliaments.³¹⁶ It is noteworthy,

however, that there is tremendous variation in adolescent freedom of movement across the country, which can be a mediating factor in adolescents' access to peer networks and safe spaces. Girls and urban adolescents are reported to encounter the greatest restrictions to their mobility, and a much lower proportion of adolescents in pastoralist communities report having close friendship networks (one quarter compared with three quarters of other adolescents).³¹⁷

Having a voice and role(s) in decision making within families are part of the participation equation. GAGE research found that younger adolescents and girls and adolescents in pastoralist communities had much less agency, compared to other adolescents.³¹⁸

OTHER ASPECTS OF ADOLESCENT

WELFARE—Adolescence is a critical period requiring supportive home environments and adequate parental care. According to a recent landscape analysis on adolescents, large numbers of adolescents do not live with either parent.³¹⁹ However, data on the home lives of adolescents are limited.

2.7.3. Sector-specific recommendations

1. In light of the myriad health and nutrition policies, strategies, plans and guidelines that include but do not exclusively focus on adolescents, advocate for greater resource allocation and tracking of adolescent-sensitive programming.
2. Explore how: (a) the next phase of PSNP (or other social protection schemes); and (b) private-sector entities can explicitly contribute to outcomes related to adolescents (e.g., ending child marriage, completing at least a secondary school education, acquiring skills for employability, facilitating adolescent civic participation, addressing mental health needs).
3. Use learning and approaches from other issues that have involved multi-stakeholder, multisectoral action (e.g., HIV,

314 UNICEF. 2018. *Ending Child Marriage: A profile of progress in Ethiopia*, UNICEF, New York.

315 Central Statistical Agency and UNICEF. *Multi-dimensional Child Deprivation in Ethiopia*. p. 49.

316 Jones, N., Presler-Marshall, E., Hicks, J., Baird, S., Devonald, M., Neumeister, E., Yadete, W. and Kebede, M. 2019. *Adolescent Psychosocial Well-being and Voice and Agency in Ethiopia*. A report on GAGE Ethiopia baseline findings. London: Gender and Adolescence: Global Evidence.

317 Ibid.

318 Ibid.

319 Truebwasser, Ursula. 2017. *Landscape Analysis of Adolescent Health and Nutrition in Ethiopia*, September 2017.

nutrition) to institute a platform focused on adolescents.

4. Invest in more safe spaces, both virtual and in person, for adolescents.

2.8. Child protection

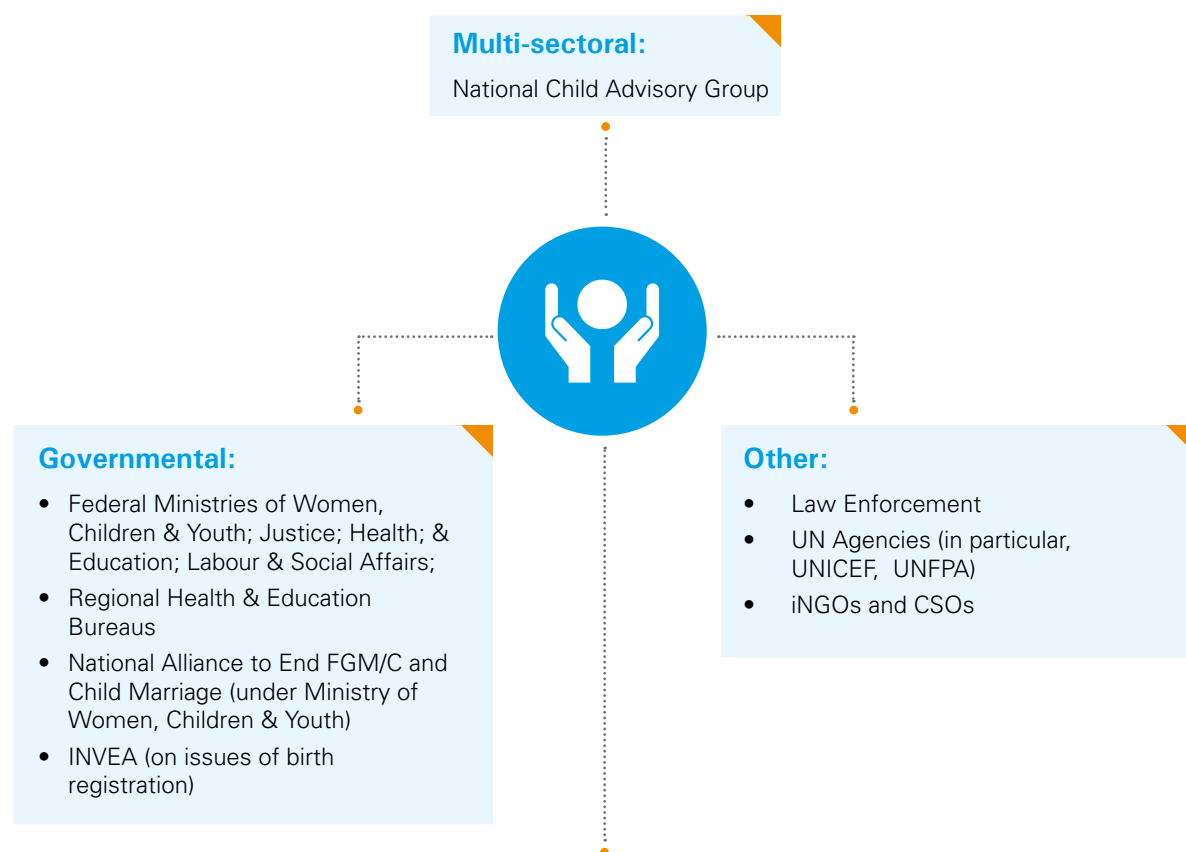
Protection is foundational to all programmes aimed at safeguarding the rights and improving the welfare of children and women in Ethiopia. As such, the majority of rights are outlined in the CRC and CEDAW.

2.8.1. Policy and stakeholder landscape

Figure 15 highlights key features of the policy and stakeholder landscape related to child protection in Ethiopia. Child protection requires commitments and inputs across multiple sectors and stakeholders, with functional coordination mechanisms to ensure coherence across the child protection system. New entities have emerged since the 2015 Situation Analysis, for example, the Immigration, Nationality and Vital Events Agency (INVEA) (Figure 35). In addition,

Figure 35. The policy and stakeholder landscape related to child protection

KEY ENTITIES AND STRUCTURES IN THE CURRENT CHILD PROTECTION LANDSCAPE



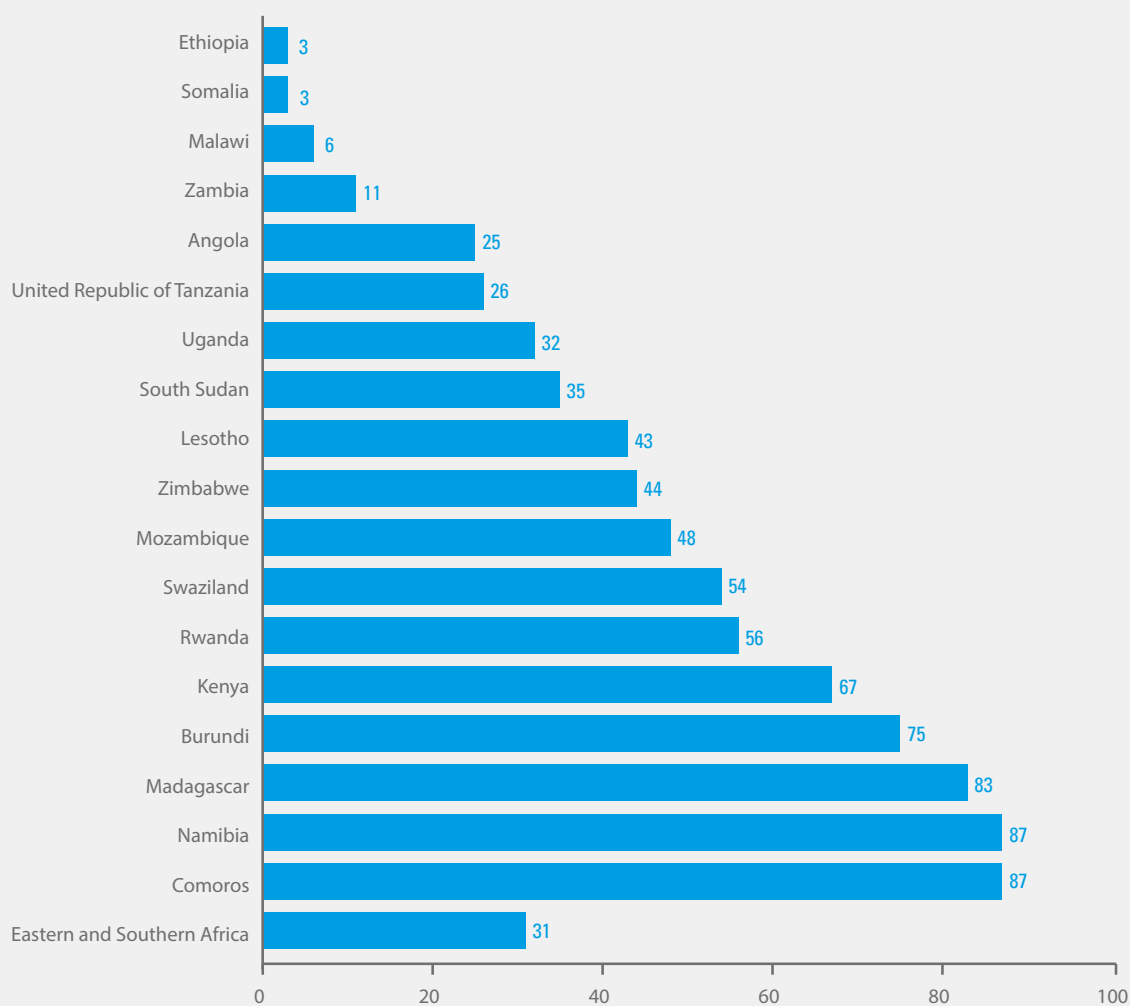
THE CURRENT POLICY AND LEGAL LANDSCAPE RELATED TO CHILD PROTECTION

- National Children's Policy (2017)
- Ethiopia National Refugee Child Protection Strategy 2017-2019
- Federal Revised Family Code (2018), ending intercountry adoption
- Proclamation No. 909/2015 on Prevention & Suppression of Trafficking in Persons and Smuggling of Migrants
- Code of Conduct on School Related Gender Based Violence
- Proclamation no. 1049/2017 on Vital Events Registration and National Identity Card (amendment of Proclamation no. 760/2012)
- Vital Events Registration Strategy 2008-2012 E.C. (2015/16-2019/20)

some development partners are assisting with operational approaches to address specific dimensions of child protection. For example, UNICEF has been supporting the Ministry of Women, Children and Youth on issues such as the development of a national costed five-year roadmap (2020-2024) to end child marriage and FGM, with federal and regional costed plans.

In 2016, the rate of children under the age of 5 who had their birth registered was 3 per cent (12 per cent urban and 2 per cent rural). Of these, 2 per cent have a birth certificate.³²⁰ As shown in **Figure 36**, Ethiopia's rate of birth registration is the lowest in Eastern and Southern Africa and is on par with Somalia's.

Figure 36. Percentage of children under age 5 whose births are registered



Notes: Data for Namibia include children with a hospital card. Data for Malawi refer only to children with a birth certificate. The regional average is based on a subset of 18 countries with available data covering 91 per cent of the regional population of children under age 5.

Source: Ethiopia Demographic and Health Surveys latest data available.

2.8.2. Levels, trends and differentials in key indicators

BIRTH REGISTRATION—State-issued, state-recognized documentation is a problem. Ethiopia's birth registration system is in the nascent stages, with the formal entity, the INVEA, recently established as a focal government institution for civil registration.

Within Ethiopia, where a child lives greatly impacts his or her likelihood of having a registered birth: almost one quarter (24 per cent) of births in the urban centre of Addis Ababa and 19 per cent of births in the urban

³²⁰ The percentage of de jure children under age 5 whose births are registered with the civil authorities, Ethiopia EDHS 2016.

centre of Dire Dawa are registered.³²¹ In contrast, the rate of birth registration is only 2 per cent in rural areas. The likelihood of birth registration also increases with household wealth quintile (from 1 per cent among the poorest children to 10 per cent among the wealthiest children).³²²

Nonetheless, data from the regions show improvements in the number and timeliness of birth registrations, particularly in three emerging regions: Benishangul Gumuz, Afar and SNNP.³²³

There are operational considerations nationwide. The new law on civil registration (Proclamation No. 1049 of 2017) assigns additional birth notification responsibilities for both institutional and non-institutional births. Currently, both the father and mother need to be present for registration, which creates barriers: parents may not be able to afford registration costs; the pastoralist lifestyle creates challenges for registration; and the process of registration may be unclear. The Federal and Regional Vital Events Registration Agencies are relatively new institutions and have not matured yet. There is a lot of turnover of kebele managers at the local level, and human resource capacity should be strengthened. Some registration offices at the local level still lack infrastructure, such as furniture or a printer. In general, there is a lack of awareness of the importance of birth registration.

CHILD LABOUR— Social and gender norms are a key driver of child labour patterns, with an expectation for boys to contribute to economic activities (**Box 10**).³²⁴ According to the 2015 National Child Labour Survey, 71 per cent of children aged 5-17 years were engaged in household chores, with girls (79.3 per cent) more likely to engage in household chores

Box 10.

VOICES OF CHILDREN AND ADOLESCENTS

'... our challenges that are affecting our aspirations are excessive workloads in rain-fed and irrigation agriculture, lack of high school in our kebele, and inaccessible roads. To improve our lives we want, therefore, support for interventions, like the establishment of high school, construction/maintenance of the existing road and above all, awareness creation training for our parents on child labour.' (Tigray, Adishum Bereket kebele, FGD with older boys).

Taken from UNICEF Ethiopia-commissioned research: Oxford Policy Management and the Horn Economic and Social Policy Institute (2018) *Generation El Niño: Long-term impacts on children's well-being: Final Report*. UNICEF: Ethiopia Country Office

than boys (63.5 per cent).³²⁵ One out of every two 5- to 17-year-olds (51 per cent) engage in economic activities. Boys (67.8 per cent) are more engaged in economic activities than girls (46.5 per cent). Most of them live in Amhara (64 per cent) and Oromia (54.4 per cent). The proportion of children who participated in economic activities among the 14- to 17-year age group was 65.4 per cent, while this was 41.7 per cent for the 5- to 11-year age group.

Based on the child labour criteria mentioned earlier 'child labour' (i.e., work that affects children's physical and mental development, exposes children to safety and health problems, affects their educational opportunities and school attendance, exposes them to working long hours with minimum payment, is exploitative in nature, and reflects an employee-employer relationship), the 2015 National Child Labour Survey found that 24.2 per cent of children aged 5-17 years (29.1 per cent among males, 18.9 per cent among females) are engaged in child labour.³²⁶

VIOLENCE AGAINST CHILDREN AND

WOMEN— According to the 2016 EDHS, more than one out of every four females aged 15-49

321 Central Statistical Agency and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: Central Statistical Agency and ICF. Table 2.11.

322 Ibid.

323 UNICEF ECO, Birth Registration Graphs and Tables, 2018, with a reference to the Immigration, Nationality and Vital Events Agency.

324 Central Statistical Agency and International Labour Organization. 2018. 2015 Ethiopia National Child Labour Survey.

325 Ibid.

326 Ibid., Table 7.12

years (26 per cent) reported ever experiencing physical or sexual violence.³²⁷ Disturbingly, 12 per cent of 15- to 17-year-olds and 17 per cent of 18- to 19-year-olds have experienced violence.³²⁸ Young Lives research showed that violence against children, largely in the form of physical punishment and emotional abuse, is prevalent and normalized, whether it occurs at home or in institutional settings, such as schools.³²⁹ By age 8, almost 4 out of 10 children (38 per cent) have experienced corporal punishment in schools, with higher proportions reported by boys and by children living in urban areas.³³⁰ Comparing reported data from Ethiopian children with data from other Young Lives countries (India, Peru and Viet Nam), Ethiopia has the second-highest prevalence of corporal punishment.

A qualitative study on violence affecting children and youth in Ethiopia (August 2019) found that understanding of violence focused on corporal punishment and sexual violence, with less appreciation of emotional and psychological violence.³³¹ Gender and age differences were apparent, with corporal punishment more common in middle childhood (above age 8). Older girls were at greater risk of gender-based violence, while boys were at risk of exploitation at work. The study identified that most cases of violence go unreported or are dealt with by informal means. In particular, vulnerable children and young people are unlikely to report cases of violence, especially rape or sexual assault. Constraints on reporting violence to institutions in the formal system were particularly apparent with regard to cases of rape. This was due to a variety of issues, including stigma and discrimination, family reputation, requirements by police and courts to produce witnesses, a lack of information on how, when and to whom to report, a lack of follow up when cases are

reported, and allegations of bribery within informal and formal institutions.

Marginalized sub-populations, such as disabled children and adolescents, are more vulnerable to violence than others, finding themselves in situations where they may have limited mobility and limited ability to communicate, or among caregivers and household members who lack the awareness, knowledge and/or skills to accommodate their special needs.³³²

Humanitarian crises may also create scenarios that elevate the risk of violence. Although data are scarce, there are reports of sexual violence against women and girls in conflict-affected areas.³³³ Evidence emerging from humanitarian settings shows that sexual and gender-based violence disproportionately affects female refugees, who are highly vulnerable to violence (rape, physical assault) when searching for basic yet scarce household resources, such as water or firewood for cooking.^{334,335} Available evidence also suggests that, within the context of emergencies, some adolescent girls and women adopt negative coping strategies, such as transactional sex, where individuals are highly exposed to HIV infection, child marriage, FGM and child labour.³³⁶ These realities highlight how humanitarian events can exacerbate the risks of and exposure to violence.

CHILDREN ON THE MOVE—Sections 1.3 and 1.7 shone a light on children on the move, a vulnerable sub-population of children consisting of child refugees, child asylum seekers, child IDPs and returnees from countries such as Yemen and Saudi Arabia. Children on the move have special protection needs given their exposure to violence and exploitation, deprivation of vital social services, such as education, and unmet needs for psychosocial

327 Central Statistical Agency and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: Central Statistical Agency and ICF. Table 15.7.

328 Ibid.

329 Pankhurst, A., Negussie, N. and Mulugeta, E. 2016. Understanding Children's Experiences of Violence in Ethiopia: Evidence from young lives. Innocenti Working Paper WP-2016-25, November 2016.

330 Ibid.

331 UNICEF. 2019. 'Ethiopia Research Brief 2: Violence affecting children and youth in Ethiopia: Insights from a qualitative study'.

332 Development Pathways. 2019. Situation and access to services of people with disabilities and homeless people in Addis Ababa.

333 Humanitarian and Disaster Resilience Plan Mid-Year Review, 2018, pp. 2, 7 and 33-35.

334 Energy and Environment Working Group. n.d. Brief on 'Access to Energy: Safeguarding refugee women and girls'.

335 United Nations Office for the Coordination of Humanitarian Affairs. 2018. 'Mapping of Recurrent Climate Shocks and Humanitarian Impact vs Development Programming' (Draft).

336 Girls not Brides. 2018. Child Marriage in Humanitarian Settings.

support.^{337, 338} Women and girls spend more time and walk greater distances to collect water, sometimes taking several hours, exposing them to sexual violence.³³⁹ Children have reported emotional distress and limited hope in terms of future opportunities.³⁴⁰ Migrant children, who are a sub-population of children on the move, also face protection risks when they cross borders irregularly to seek income-generating opportunities in other countries.

Movement is not always due to humanitarian factors. For example, as stated earlier in this report, out-of-school adolescent girls constitute one of the largest groups of individuals to migrate from rural to urban areas.³⁴¹ Children are very aware of vulnerabilities associated with this reality (Box 11).



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337 UNICEF. 2018. Data Brief on Children on the Move: Key facts and figures.

338 UNICEF ESARO, Protecting Children on the Move in Eastern and Southern Africa, Concept Note, Oct. 2017, pp. 4-5; United States Department of State, Human Trafficking Report. Ethiopia, 2018, p. 185.

339 Women and girls bear the primary responsibility of water fetching. See EDHS, p. 19. In response to water scarcity, water trucks delivered drinking water to 3 million people in 188 woredas in 2015/16 and continued water trucking in 2016/17 reached another 2.6 million people in 102 woredas. United Nations Office for the Coordination of Humanitarian Affairs, 'Mapping of Recurrent Climate Shocks and Humanitarian Impact vs Development Programming' (Draft), 2018.

340 UNICEF, Generation El Niño: Long-term impacts on children's well-being. Final Report, 2018, p. 22.

341 Erulkar, Annabel, Girmay Medhin and Lemi Negeri. 2017. The Journey of Out-of-School Girls in Ethiopia: Examining Migration, Livelihoods, and HIV. Addis Ababa: Population Council.

Box 11.

VOICES OF CHILDREN AND ADOLESCENTS

'Migrant children working as housekeepers are usually exploited and exhausted, and they cannot properly attend school. Some of them decide to attend evening classes even when their employers disagree. Younger girls that attend evening classes are usually afraid of walking in the dark late at night for the risk of rape and physical harassment. We heard that strangers recently kidnapped a girl who was going to school late in the evening, and they took her kidneys. That girl was found dead shortly after. We have also heard that strangers abduct young children and traffic them.' (Children participating in an FGD in Kolfe Karaniyo, 2018)

Taken from UNICEF Ethiopia-commissioned research: Overseas Development Institute and Ethiopian Development Research Institute. 2018. Urbanization Trends, Urban Child Poverty and Vulnerabilities in Ethiopia.

HARMFUL PRACTICES—There has been notable progress in reducing child marriage. **Figure 37** shows the trend in marriage before age 18 since 1980. According to the 2016 EDHS, 40 per cent of females aged 20-24 years were married by age 18, while 14 per cent were married by age 15.³⁴² The median age at first marriage (17.1 years according to the 2016 EDHS) has steadily increased in recent years. It should be noted, however, that despite this progress the median age at first marriage is still below the legally permitted age of marriage (18 years).

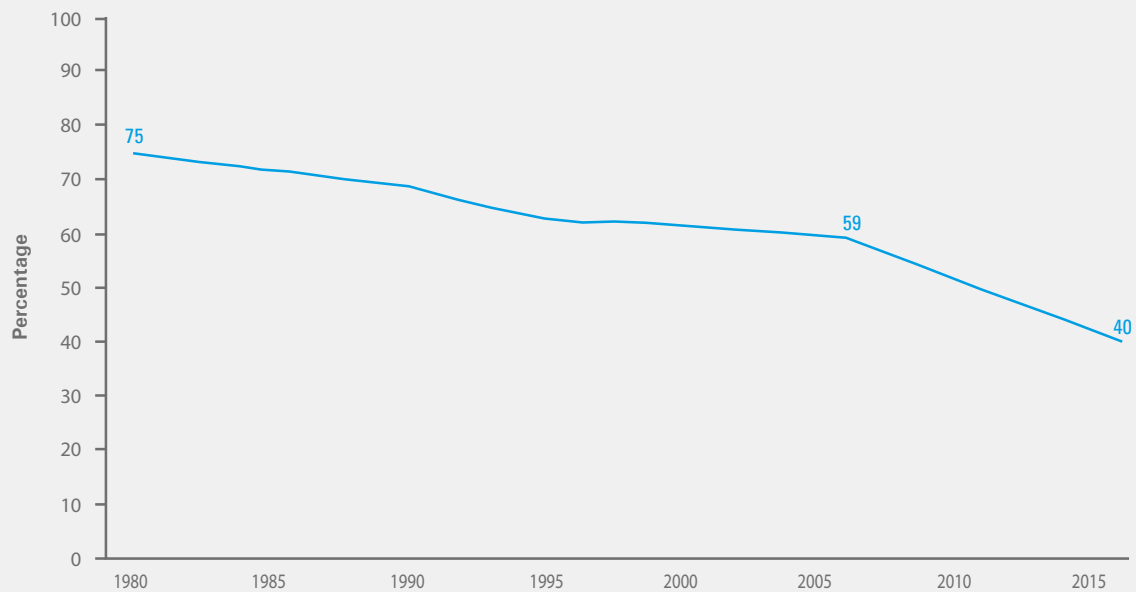
Compared to progress over the past 10 years, progress will need to be six times faster if child marriage is to be eliminated by 2030.³⁴³ Enforcement of existing legislation is an identified bottleneck, and regional differences are stark, with the median age at first marriage being as low as 15.7 years among women in Amhara, compared with 23.9 years among women in Addis Ababa.³⁴⁴ Limited evidence

342 EDHS 2016, Table 4.3.

343 UNICEF. 2018. Ending Child Marriage: A profile of progress in Ethiopia. UNICEF: New York.

344 Central Statistical Agency and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: Central Statistical Agency and ICF. Table 12.1.

Figure 37. Percentage of women aged 20 to 24 years who were first married or in a union before age 18



Note: This trend analysis is based on the prevalence of child marriage across age cohorts, as measured in the Ethiopia Demographic Health Survey 2000, 2005, 2011 and 2016.

Source: United Nations Children's Fund, *Ending Child Marriage: A profile of progress in Ethiopia*, UNICEF, New York, 2018.

on the impact of humanitarian crises on adolescents shows that drought contributed to a reduction in child marriage, as families could not afford to organize weddings.³⁴⁵

The aforementioned evidence suggests that it is critical to address deeply entrenched gender and social norms at the community level to reduce the incidence of harmful practices in Ethiopia.

The 2016 EDHS examined women's autonomy and found that, while younger women were more likely than older women to make the decision to marry, less than half of young women (41.2 per cent of ever-married women aged 15-19 and 46.77 per cent of ever-married women aged 20-24) have this autonomy, compared to 20.8 per cent to 32.5 per cent of older women.³⁴⁶

FGM has declined since 2000 when it was documented that 8 out of every 10 females in

Ethiopia had undergone some form of FGM.³⁴⁷ However, the national average is still high (65 per cent in the 15-49 year age group) according to the 2016 EDHS. In Afar and Somali, the practice is still almost universal among women of reproductive age.³⁴⁸ There are starker regional differences in the prevalence of FGM in present-day Ethiopia than there were in 2000. Reported FGM rates are far lower among girls aged 0-14 years (15.7 per cent) than among all women of reproductive age. However, to eliminate FGM by 2030, progress will need to be seven times faster than the progress observed over the past 10 years.³⁴⁹

Enforcing legislation on the harmful practices of child marriage and FGM (FGM is prohibited by the criminal code, while federal law prohibits child marriage) is a means of thwarting those practices on a large scale. Tackling gender and

³⁴⁵ The Global Partnership to End Child Marriage. 2018. *Child Marriage in Humanitarian Settings*.

³⁴⁶ Central Statistical Agency and ICF. 2016. *Ethiopia Demographic and Health Survey 2016*. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: Central Statistical Agency and ICF.

³⁴⁷ Central Statistical Authority and ORC Macro. 2001. *Ethiopia Demographic and Health Survey 2000*. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Authority and ORC Macro.

³⁴⁸ Central Statistical Agency and ICF. 2016. *Ethiopia Demographic and Health Survey 2016*. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: Central Statistical Agency and ICF.

³⁴⁹ UNICEF. 2018. *Ending Child Marriage: A profile of progress in Ethiopia*. UNICEF: New York.

social norms at the community level is equally important; it is intensive and takes much longer to effect change. Leadership from focal institutions such as MoWCY at both federal and regional levels can foster an enabling environment for change.

JUSTICE FOR CHILDREN—Up-to-date evidence on justice for children in Ethiopia is highly limited. The globally recommended minimum age of criminal responsibility is 12 years, far higher than Ethiopia's age of criminal responsibility (9 years), with the justice system treating children older than 15 years as adults. Civil society organizations have been active in the child-friendly justice arena, and there has been a need for harmonized action across all actors. In 2018, the Federal Supreme Court and Justice for All-PF Ethiopia held a validation workshop with an array of country and regional justice stakeholders to validate draft Child Justice Guidelines.³⁵⁰

During the African Child Policy Forum's Continental Conference on Access to Justice for Children in Africa (May 2018 in Addis Ababa), Ethiopia's Children's Legal Protection Centre, which was launched in 2012 and is currently hosted by the Federal Supreme Court, was highlighted among regional examples.³⁵¹ Although the centre has introduced a referral pathway to help a child navigate the justice system when he or she comes in contact with the law, there is recognition that the scale of this effort needs to be expanded to benefit children nationwide.

Other concepts and models, such as child-friendly benches within courts, have been introduced in the past in some regional towns, with support from development partners such as UNICEF and the Danish Government. However, there is a need for stakeholders to devise a package of justice-for-children interventions and services that are documented to be effective, scalable and sustainable, as well as a need for timely and complete administrative data related to justice for children.

350 Justice for All-PF Ethiopia. 2018. Workshop on the Validation of Draft Child Justice Guideline. <https://jfapfe.org/workshop-on-the-validation-of-draft-child-justice-guideline/>

351 African Child Policy Forum. 2018. Conference Report for Continental Conference on Access to Justice for Children in Africa: Spotlighting the Invisible, Addis Ababa, 8-10 May 2018.

CHILDREN WITH INADEQUATE PARENTAL CARE—One out of 10 children in Ethiopia under age 18 do not live with a biological parent, and 7 per cent of these children are orphans, with one or both parents dead.

Adolescents are most likely to be orphans (10 per cent among 10- to 14-year-olds and 17 per cent among 15- to 17-year-olds, compared with 2 per cent to 6 per cent of children under age 9).³⁵² Gambella Region has the highest percentage of orphans (13 per cent), while Tigray, Amhara, Oromia, Benishangul-Gumuz, and Harari have the lowest percentages of orphans (each with 7 per cent).³⁵³

There have been legislative milestones related to children with inadequate parental care. The country developed the Alternative Childcare Guidelines on Community-Based Childcare, Reunification and Reintegration Programme, Foster Care, Adoption and Institutional Care Service. Parliament passed a proclamation to amend articles in the Family Code to ban international adoption in January 2018.³⁵⁴ There is scope to further align the country's policies and practices on children with inadequate parental care with international best practices and conventions.

When there are limited options for alternative care, disintegration of the family unit can lead to children living and/or working on the street (referred to as 'children in street situations'). In a study on children living in street situations in Hawassa City, breakdown of the family, death of a parent or guardian and disagreements within the family were all identified as push factors that drove children to street situations.³⁵⁵ Recent research on urban destitution found that children in street situations with their parents are able to access education, although they must contend with an array of challenges, such as hunger, lack of electricity that makes it difficult to do homework, psycho-social problems, child

352 Central Statistical Agency and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: Central Statistical Agency and ICF. Table 2.10

353 Ibid.

354 UNICEF Eastern and Southern Africa Regional Office. Child Notice Ethiopia 2018.

355 Kassa, Shimelis. 2018. The Situation of Street Children in Urban Centers of Ethiopia and the Role of NGO in Addressing their Socio-Economic Problems: The case of Hawassa City. 10.14662/IJARER2015.012.

labour to cover associated costs of education, for example uniforms and educational materials, and other factors linked with an unsafe, unclean environment.³⁵⁶ The same study highlighted the need to better support grassroots actors, such as CSOs that are already providing services to urban destitute children, whether unaccompanied or with their families, and supply-side strengthening such as the use of outreach teams of trained social workers to interface with children.

2.8.3. Drivers of identified shortfalls and differentials

Figure 38 presents a causal pathway for identified shortfalls and differentials related to child protection. At this junction in the evolution of child protection in Ethiopia, the largest driver of shortfalls and inequities is the need for a coherent, functional child protection system. However, gender and social norms and beliefs that place little value on girls' education and attach social stigma to females who are unmarried also underlie harmful practices.³⁵⁷ The Young Lives research shed light on the link between household factors (poverty, inequality, death of a parent, divorce) and violence in the home.³⁵⁸ Hence, addressing different dimensions of child protection must entail a balance between strengthening systems and tackling underlying and structural factors that underpin various shortfalls and violations related to child protection.

2.8.4. Sector-specific recommendations

1. As recommended in the previous Situation Analysis in 2015, prioritize the operationalization of a case management system for child protection, with a focus on: (a) ensuring standardization of tools

and approaches, (b) information flow and coordination between actors operating within the same jurisdiction and across different levels (e.g., kebele, woreda, zone), and (c) a 'trickle-down' of case management capacity to the lowest implementation level. There should be investment in a national child protection management information system for complete and up-to-date administrative data on various dimensions of child protection across child protection actors and allied sectors. Consideration should be given to how that system operates in humanitarian and non-humanitarian settings.

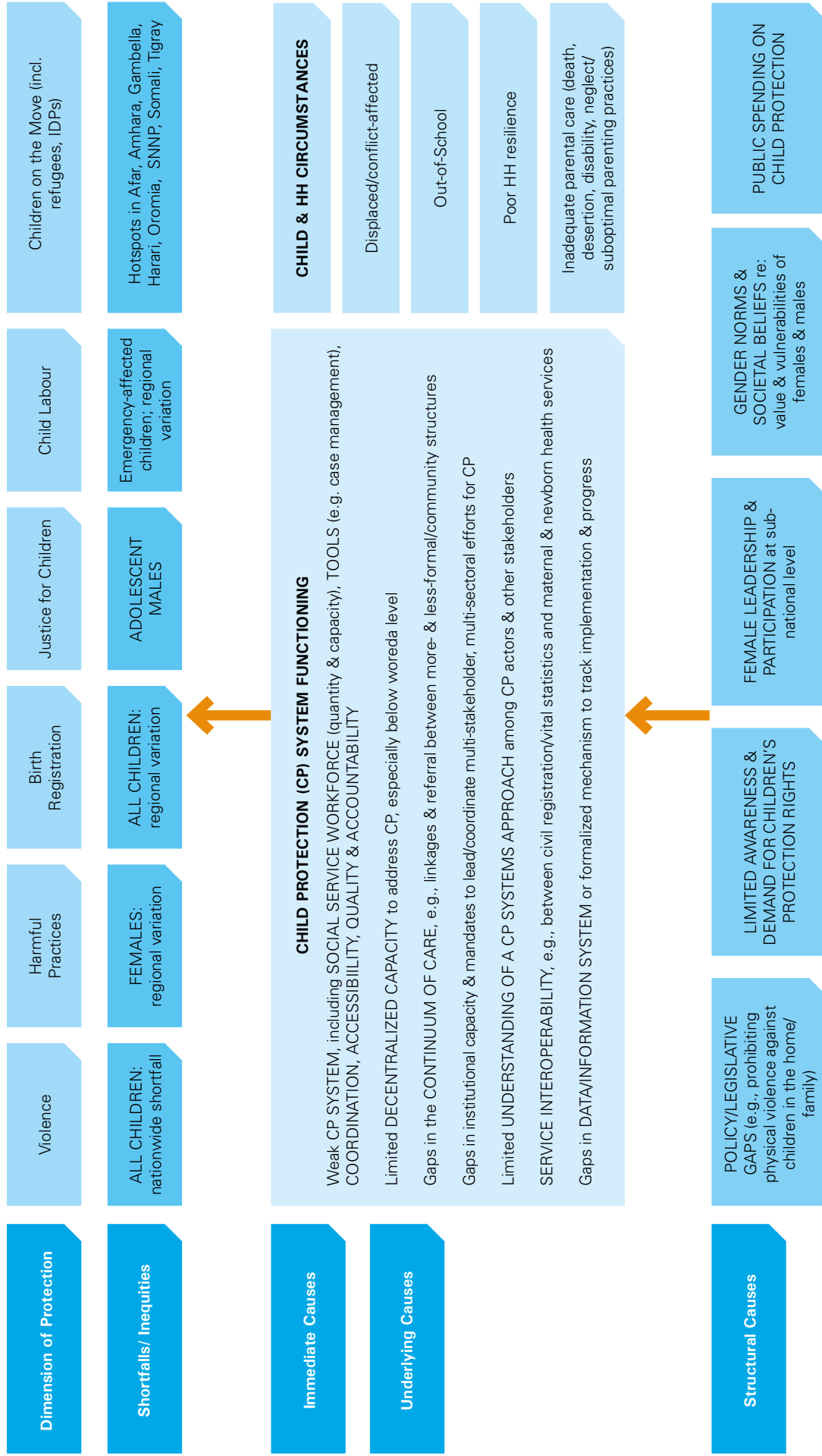
2. Strengthen coordination platforms at sub-national (regional, woreda, kebele) levels to ensure coherence and accountability across the different child protection actors. Those forums should focus on greater service integration, for example between education, health, WASH and social protection, to address child protection in both emergency and non-emergency settings. MoWCY has a pivotal role to play in coordination.
3. Introduce and/or strengthen forums or platforms that provide a voice to children, including adolescents, in efforts to: (a) identify child protection needs, (b) design child protection services and interventions, and (c) assess progress in addressing all dimensions of child protection. Both in-person forums (in schools, youth clubs) and virtual forums (via social networking) should be explored.
4. Devise behaviour change strategies that target and engage parents/caregivers and grassroots actors in child protection at the household level (birth registration, violence prevention, and addressing norms and beliefs that underpin some adverse outcomes, such as harmful practices).

³⁵⁶ Development Pathways. 2019. Situation and Access to Services of People with Disabilities and Homeless People in Addis Ababa.

³⁵⁷ The Early Marriage Fund Secretariat, Plan International Ethiopia and Ethiopian Society of Sociologists, Social Workers and Anthropologists. 2017. Prevalence, Drivers and Protective Factors of Early Marriage in Amhara, Oromia and SNNP Regions of Ethiopia.

³⁵⁸ Pankhurst, A., Negussie, N. and Mulugeta, E. 2016. Understanding Children's Experiences of Violence in Ethiopia: Evidence from young lives. Innocenti Working Paper WP-2016-25, November 2016.

Figure 38. Causal pathway for identified shortfalls and inequities in Child Protection



2.9. Social protection

Consistent with the definition used in the African Union Social Policy Framework, Ethiopia's NSPP 2014 defines social protection as: "A set of interventions that aim to reduce social and economic risks, vulnerabilities and deprivations for all people."

2.9.1. Policy and stakeholder landscapes

There have been noteworthy additions to social protection (**Figure 39 on page 89**) in Ethiopia. As well as the NSPP, there are corresponding strategic documents, such as the National Social Protection Strategy of 2016 and national and regional social protection action plans.

The social protection landscape is evolving, with recalibration of roles and responsibilities among various Government of Ethiopia agencies. Nonetheless, MoLSA, which was a central actor in developing both the NSPP and National Social Protection Strategy, currently chairs a multi-stakeholder national social protection platform. There is a vision for a federal social protection council to be established by the end of 2019 to improve the coordination of NSPP implementation. Although not well documented, informal mechanisms exist that centre on extended families and communities.³⁵⁹ CSOs have implemented stand-alone programmes that entail cash transfers, social services and social insurance schemes.

2.9.2. Social protection mechanisms and programmes in present-day Ethiopia

Several forms of social protection exist, although Ethiopia actually has very little child-focused social protection. The Rural Productive Safety Net Programme, 2015-2020 (referred to as PSNP 4) and the Urban PSNP (USPNP), which launched in 2016, serve as the backbone of Ethiopia's current child-sensitive social protection system (**Box 12**).

³⁵⁹ E.g. Busa Gonofa is a traditional insurance scheme for families in crisis in Oromia, and Gudifecha is a tradition by which better-off relatives take care of the children of poorer relatives.

Box 12.

THE TWO MAIN CHILD-SENSITIVE SOCIAL PROTECTION PROGRAMMES IN ETHIOPIA

Productive Safety Nets Programme (PSNP)

- Started in 2005
- Currently in fourth round (PSNP 4)
- Spans Afar, Amhara, Dire Dawa, Harar, Oromia, SNNP, Somali and Tigray
- Current reach: 8 million chronically food-insecure people (2.5 million households) across 350 woredas in exchange for working on public projects during the lean season of the year (six months)

Urban Productive Safety Nets Programme (USPNP)

- Started in 2016
- Covers 11 major regional cities
- Employs a quota system (set number of enrolled households per woreda)
- Has a third target group of urban destitute people, including children in street situations

The country is in the nascent stages of adopting a systems-approach to social protection, with more-clearly defined and effective institutional arrangements, budgetary tracking and targeting mechanisms. Part of this systems approach would entail a single management information system for social protection. Under PSNP 4, a new rural safety net management information system is under development.³⁶⁰ However, Ethiopia is still transitioning toward integrated social protection programming and service delivery that centres on grassroots collaboration and coordination between frontline providers, such as social workers, health extension workers, development agents, community care coalition members and other actors and entities at kebele level.

THE RURAL PSNP—PSNP has its origins with the Ministry of Agriculture, but the programme has since evolved and is currently co-managed by MoLSA and the Ministry of Agriculture,

³⁶⁰ The World Bank. 2018. Ethiopia Rural Productive Safety Net Project, Implementation Status and Results Report, Oct. 2018, pp. 1-9.

as MoLSA is in the process of taking over the management of the social assistance component of the PSNP. PSNP 4 operates in Afar, Amhara, Dire Dawa, Harar, Oromia, SNNP, Somali and Tigray.³⁶¹ It provides regular cash and food transfers to approximately eight million chronically food-insecure people (2.5 million households) across 350 woredas.³⁶² This cash assistance is given in exchange for working on public projects during the lean season of the year (six months). There are two main types of direct support clients: (1) permanent direct support clients (individuals who are chronically or suddenly food insecure, with no adequate family support, or without adult able-bodied labour), and (2) public works clients, who receive a conditional cash transfer for a certain amount of work benefitting the public good. The temporary direct support clients are public works clients who transition to the permanent direct support component while pregnant or lactating, as well as while taking care of a malnourished child.

Building on the lessons learned under previous phases of the PSNP, the PSNP 4 makes explicit links between various social services (health and nutrition, WASH, education, child protection, social protection), with the express aim of improving child nutritional status. PSNP 4 also has formal links with disaster risk management efforts.³⁶³ In 2017/2018, there have been improvements in the timeliness of cash transfers to beneficiaries, however there are still challenges in several woredas due to insecurity in Somali and Oromia, as well as administrative issues.³⁶⁴

THE URBAN PSNP (UPSNP)—Launched in 2016, the UPSNP components include safety net transfers, livelihood services and institutional strengthening.³⁶⁵ The UPSNP currently covers 11 cities and approximately 600,000 households. As a social protection mechanism that is still in the nascent stages, awareness among community members about its existence is steadily growing.³⁶⁶ However, there are inherent design issues that have created a challenge to linking all eligible households with UPSNP social assistance. More specifically, there is a quota for the number of participating households in each woreda, which has resulted in some urban poor people being left out.

NON-PSNP SOCIAL PROTECTION MECHANISMS IMPLEMENTED BY THE GOVERNMENT

—In the health sector, the government introduced CBHI in 375 woredas in 2017/2018, covering 15 per cent of all households in that year, with an 80 per cent target for 2019/2020.³⁶⁷ However, a UNICEF assessment of CBHI-PSNP links in 2017 documented low participation of PSNP beneficiaries in CBHI (22 per cent of public work clients and 21 per cent of permanent direct support clients).³⁶⁸ It should be noted however that there is limited geographical convergence of the two programmes: only 31 per cent of woredas in Amhara, Oromia, SNNP and Tigray in 2016.

In non-CBHI woredas, the government is implementing an Indigent Health Fee Waiver system that waives user fees at public-sector facilities for the very poor and for people with

361 The Household Asset Building Programme (HABP) is reformulated and integrated in the PSNP 4 design. The former resettlement programme and the Complementary Community Investment Programme (CCIP) were discontinued.

362 The total caseload is 10 million people.

363 World Bank. 2015. Ethiopia - Poverty Assessment 2014, p. 46; Federal Democratic Republic of Ethiopia, Ministry of Agriculture, 'Productive Safety Net Programme 4. Design Document, 2014', p. 6. See the National Policy and Strategy on Disaster Risk Management, which aims to reduce the risks and impacts of disaster through, among others, a social protection policy.

364 The World Bank. 2018. Ethiopia Rural Productive Safety Net Project, Implementation Status and Results Report, Oct. 2018, pp. 1-9.

365 The World Bank. 2018. Poverty & Equity Brief. Ethiopia, p. 1. See also Federal Democratic Republic of Ethiopia, National Planning Commission, Ethiopia's Progress Towards Eradicating Poverty: An interim report on 2015/16 Poverty Analysis Study, 2017, pp. 16 and 20.

366 UNICEF. 2018. 'Situation of Urban Destitute Populations and their Access to Social Services and Safety Net Programmes in Ethiopia', Draft report, Oct. 2018, pp. 27-29. See also UNICEF SPESI, Programme Strategic Note Mid-Term Review, 2017, p. 9.

367 Ibid.

368 UNICEF. 2017. Reaching the Poor: Synergies and Complementarities of the Productive Safety Net Programme and Community-Based Health Insurance, pp. 1-73.



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medical emergencies who cannot pay medical expenses. In 2017/2018, regional and woreda governments financed the coverage of 7.7 per cent of households through this mechanism, however there is scope for better links between the fee-waiver system and PSNP to extend the benefits to more people.³⁶⁹

The education sector has instituted several social protection mechanisms, most of which focus on primary-school-aged children. For example, there is an Education Fee Waiver scheme and a National School Feeding Programme 2016-2020 that focuses on primary school children.³⁷⁰ Other efforts have included establishing and strengthening boarding/hostels for hard-to-reach children in pastoralist and semi-pastoralist areas (for up to 2 per cent of second cycle primary enrolment); creating mobile schools (alternative basic education) to meet the needs of pastoralist children; and providing scholarships to at-risk, poor and disadvantaged children to support their progression to the second cycle of primary education.

Other mechanisms include community-based nutrition programming (CiNUS), which mentions the PSNP as one core component, as well as potential free legal services

for vulnerable people, a variety of public and private sector pension schemes and government benefits for working mothers.

PILOT MODELS FOR SOCIAL

PROTECTION—UNICEF, with financial support from Irish Aid, is supporting MoLSA to pilot a ‘cash plus’ model called the Improved Nutrition through Integrated Basic Social Services with Social Cash Transfer (IN-SCT) programme. The programme was piloted in four woredas in Oromia and SNNP between 2014 and 2018 and phased out at the end of 2018. Gender, nutrition and social development were mainstreamed in the design and implementation of IN-SCT. For example, there was a 50 per cent reduction in the workload for all women, and a work exemption for pregnant and lactating mothers from public works for one year after giving birth, a provision that is consistent with the PSNP Programme Implementation Manual.³⁷¹ The IN-SCT established an integrated case management system for temporary direct support clients to access maternal and child health services as well as to link permanent and temporary direct support clients to education services. The case management system was implemented by a dedicated social welfare workforce and replicated in an information technology-based management information system.

The Integrated Safety Net Programme (2017-2022) is another initiative being implemented by MoLSA with UNICEF support and financial support from SIDA. The programme targets children and women living in ultra-poor and labour-constrained households of the UPSNP and PSNP 4. Three distinct elements of Integrated Safety Net Programme are: (1) its links to the CBHI programme, (2) the pioneering of the urban ‘cash plus’ pilot, and (3) its emphasis on knowledge and evidence creation to inform future advocacy and integrated, child-sensitive social protection programmes.³⁷²

369 Federal Ministry of Health. 2018. HSTP 2015/16-2019/20. Mid-Term Review (VOL. I). Comprehensive Report, p. 12.

370 NNP II, p. 20.

371 UNICEF. 2017. National Social Protection Budget Brief: 2011-2016.

372 UNICEF Ethiopia, Building an Integrated Safety Net System for the Most Vulnerable Women and Children in Rural and Urban Ethiopia, p. 2.

2.9.3. Effectiveness of current social protection mechanisms for children

Conclusions from various PSNP evaluations have been generally positive, particularly with respect to the following: (1) management of the programme, (2) beneficiary-level improvements in household food consumption, (3) poverty reduction (e.g., a 2015 World Bank poverty assessment estimating that cash transfers to vulnerable households had led to a 2 per cent decline in the national poverty rate), and (4) climate-resilient infrastructure development in rural areas (e.g., anti-erosion structures and other soil and water conservation systems).^{373,374,375}

Historically, the link between receiving PSNP food or cash transfers and nutrition outcomes in children was tenuous (e.g., improved quality of children's diets and reduced malnutrition).³⁷⁶ Through the various phases of PSNP, and pilot programmes such as IN-SCT, it is important to consider local experiences and insights when co-implementing cash transfers with complementary interventions to improve child-

related outcomes. Two such complementary interventions relate to behaviour change communication (to address knowledge and practices, such as infant and young child feeding) and links between different grassroots entities (e.g., Health Development Army, Community Care Coalitions) and service providers.³⁷⁷

External factors such as inflation, high food prices, drought, political instability and overall water scarcity have impacted aspects of the PSNP, such as the Public Works programme. For example, in 2017/2018, the public works wage rate covered only 77 per cent of average consumption; in 2018/2019 the government increased the average wage rate by 20 per cent, which was important to bolster poor households' consumption in light of rising food prices.³⁷⁸

In 2014, the cost of diet for two regional towns, Dire Dawa and Dessie, was estimated between 71,000 and 91,000 ETB/year, far lower than the maximum amount of ETB 7,500 received in the course of a year through the PSNP. Thus, there are very practical challenges that households face in overcoming the nutritional gap, even when they receive social assistance. A costed strategy with the minimum package or funding for pregnant women and malnourished children as part of temporary direct support clients is essential.

From an equity perspective, it is important to examine differences in the reach and effectiveness of some social protection mechanisms in different parts of the country. The existence of standard guidelines to inform PSNP implementation across the country has proven necessary, but not sufficient. Issues of political economy, whether through formal political parties or traditional governance structures such as clans, have shaped PSNP implementation in regions such as Tigray, Oromia and Afar.³⁷⁹ A 2018 study found that



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373 The PSNP is managed and coordinated by the Ministry of Agriculture in close partnership with the Ministry of Labour and Social Affairs.

374 World Bank. 2015. Ethiopia - Poverty Assessment 2014, p. 46, pp. 74 and 75.

375 The PSNP has a strong link with the Climate Resilient Green Economy.

376 UNICEF Ethiopia, National Social Protection Budget Brief: 2011-2016, 2017, p. 4. See also UNICEF ECO, Annual Report 2017, Ethiopia, p. 5.

377 Keetie Roelen, Stephen Devereux, Abdul-Gafaru Abdulai, Bruno Martorano, Tia Palermo and Luigi Peter Ragno. 2017. How to Make 'Cash Plus' Work: Linking cash transfers to services and sectors, Innocenti Working Paper 2017-10, UNICEF Office of Research, Florence.

378 Ibid.

379 Rift Valley Institute. 2019. 'Ethiopia Under Abiy: An age of uncertainty and opportunity', Meeting report, March 2019.

the PSNP was successful at both targeting and impact in highland areas, but fraught with targeting shortcomings in lowland areas such as Afar and Somali.³⁸⁰ More specifically, there were inclusion errors in lowland settings, where wealthier pastoralist households were just as likely to receive social assistance as the poorest pastoralist households in lowland areas. The study highlighted that traditional notions of ‘fairness’ in pastoralist settings meant that everyone in a community should benefit, regardless of wealth. The findings prompted questions around the appropriateness of highland-tested modes of targeting in the country’s lowland areas.

The next stage for the PSNP includes: (1) effective adaptations of the programme in lowland settings; (2) addressing how various hazards, such as conflict or insecurity, impacts the implementation of social programmes; (3) geographical expansion (e.g., extending UPSNP to more cities); and (4) activation of programme components (e.g., urban destitute component of UPSNP) that can extend social protection support to marginalized and/or the hardest-to-reach sub-populations of need (e.g., children in street situations).

With respect to the UPSNP, there have been concerns about the quota system (per woreda), which has seen poor households being excluded once the quota has been reached in a woreda. As a relatively new social protection programme, there also remains a lack of awareness among some community members about the existence of the UPSNP.³⁸¹

2.9.4. Under-emphasized and/or under-resourced aspects of social protection in Ethiopia

The government has made strides in leveraging both domestic and external resources for pro-poor programmes. Although there has been a recent increase in domestic financing for the PSNP, the programme largely relies on donor funding. Taking a prospective view, there will be challenges to maintaining recent and current levels of social protection spending, particularly in light of economic realities such as a decline in total government revenue.³⁸²



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There is a need to bolster resilience building, however the PSNP 4 livelihood component is heavily underfunded. Legal protection and support to segments of the society vulnerable to abuse and violence are other areas of need.

There is global momentum around adolescent-responsive social protection, and while adolescents are a highly important population segment in Ethiopia, the country’s vast social safety nets are not nuanced enough in either their targeting or their monitoring of outcomes

380 Lind, J., Sabates-Wheeler, R., Hodinott, J. and Taffesse, A.S. 2018. Targeting Social Transfers in Pastoralist Societies: Ethiopia’s productive safety net programme revisited. Ethiopian Development Research Institute Strategy Support Programme Working Paper 124, September 2018.

381 UNICEF. 2018. ‘Situation of Urban Destitute Populations and their Access to Social Services and Safety Net Programmes in Ethiopia’, Draft report, Oct. 2018, pp. 27-29. See also UNICEF SPESl. 2017. Programme Strategic Note Mid-Term Review, p. 9.

382 Endale, K., Pick, A. and Woldehanna, T. 2019. OECD Development Policy Papers February 2019 – No. 15, Financing Social Protection in Ethiopia: A long-term perspective.

to shed light on adolescent outcomes of social protection programmes. There will be a need to systematically address factors that underpin vulnerability and inequity in Ethiopia (e.g., gender and disability) as part of current and future social protection efforts.

2.9.5. Sector-specific recommendations

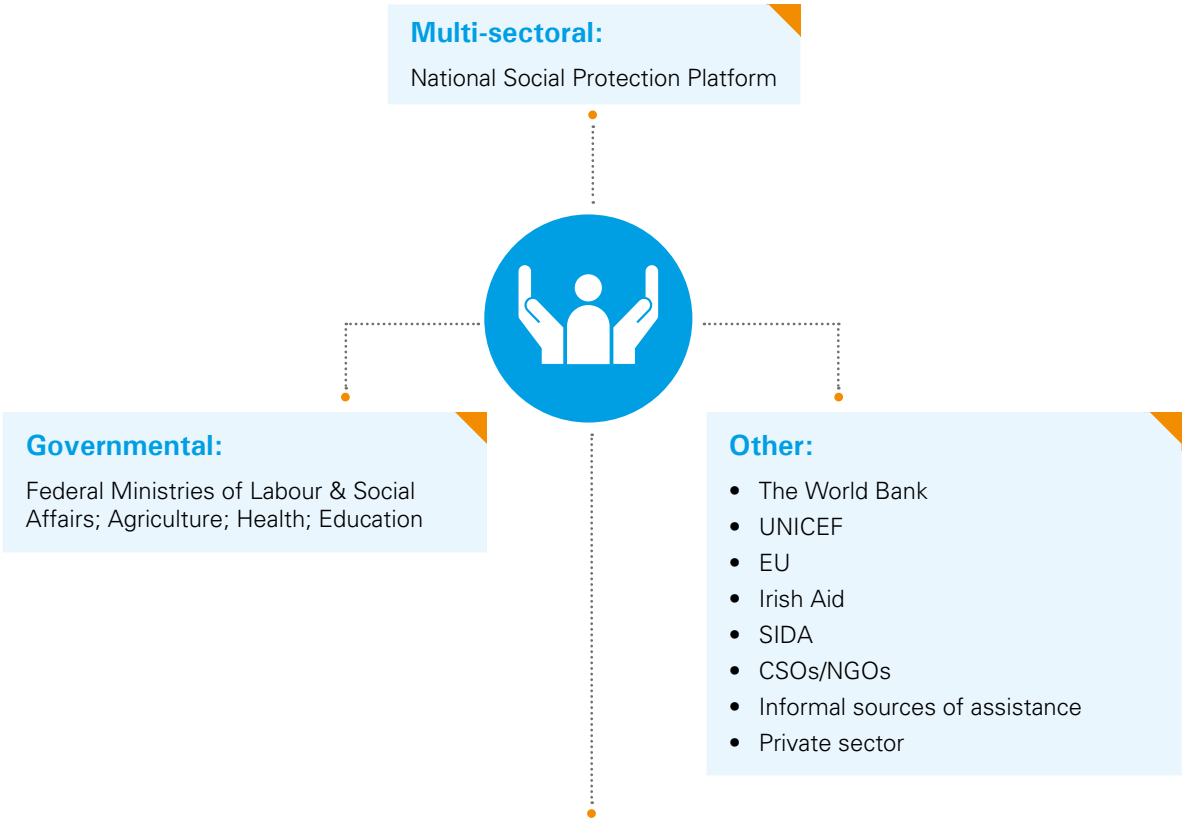
1. Aid in both resourcing decisions and cost analyses, introduce on-budget tracking of social protection spending.
2. Strengthen the contributions of the PSNP to reducing malnutrition. Increase the assistance amount provided to pregnant women and children under 5 included in temporary direct support. This will narrow the gap between the social assistance amount provided and the actual cost of an adequate diet.
3. Across social protection initiatives and actors, roll out a bona fide management information system that supports harmonized, child-sensitive monitoring of both social protection coverage and outcomes.
4. Based on the learning and evaluative evidence from pilot efforts such as IN-SCT and the Integrated Safety Net Programme, as well as evidence from social protection schemes in various sectors, develop a national package of child-sensitive social protection interventions and services.
5. As mentioned in the chapter on adolescents, explore how the next phase of PSNP and/or other social protection schemes can directly target adolescents and/or contribute explicitly to outcomes related to adolescents (e.g., ending child marriage, completing at least a secondary school education, acquiring skills for employability).
6. Introduce social protection programme components related to key elements of the NSPP that are central to tackling inequities and core vulnerabilities. In implementing the various social protection programmes, NSPP principles such as gender sensitivity, participation, human rights, inclusiveness and partnership should be reflected in practice, with a focus on addressing all main pillars of the policy.

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Figure 39. The social protection landscape in Ethiopia, 2019

KEY ENTITIES AND STRUCTURES IN THE CURRENT SOCIAL PROTECTION LANDSCAPE



THE CURRENT POLICY AND LEGAL LANDSCAPE RELATED TO SOCIAL PROTECTION

For the General Population:

- National Social Protection Policy
- National Social Protection Strategy 2016-2019
- National Social Protection Action Plan 2017-2021
- Regional Social Protection Action Plans

Guides and Materials specifically related to Children and/or Women:

- Training Guide on Gender, Social Development and Nutrition Mainstreaming in PSNP
- Programme for Equity (GEQIP-E)



3.

CROSSCUTTING RECOMMENDATIONS

1. Supporting inclusive development that maximizes positive outcomes for children, adolescents and women requires complete 'trickle down' and rational use of: (a) allocated resources (financial, human, material); (b) technical and management capacities; and (c) high-quality, high-impact services at the lowest implementation level. In the next five years, invest in streamlined / rationalized management, coordination and mutual accountability mechanisms that are evidence informed and create a space for children, including adolescents, in the sub-national implementation of national (GTP) and global (SDG) goals. This course of action can be regarded as a foundational approach that can contribute to several SDGs.
2. Leveraging the new Charities and Societies Act, and through a formal collaboration between State and non-State actors (CSOs, private-sector entities, development partners), formalize mechanisms for routine and meaningful participation of children, including adolescents, in planning processes, annual reviews and other forums in which their voices should be heard. Consider innovative modalities for their engagement, such as through social media and digital platforms, in addition to face-to-face engagement. This course of action can contribute to SDG 17 on partnerships.
3. To better position the country to reap the demographic dividend, pursue formal agreements and/or institutional arrangements (e.g., between FMoE and private-sector entities and/or CSOs) to build marketable skills in different sub-sets of children (e.g., in- and out-of-school

- adolescents, urban poor adolescents, adolescents in humanitarian settings). This course of action will contribute to SDG 4 on quality of education, as well as SDG 8, which promotes sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all.
4. Over the next two years, design and implement integrated humanitarian and development / resilience-building programmes that align development approaches with humanitarian needs emerging from displacement, migration and/or other phenomena resulting from shocks. This model would engage partners and leverage interventions from different sectors to address root causes of vulnerability to shocks and migratory pressures for 'children on the move'. As a matter of priority, this approach, that focuses on the humanitarian-development nexus, should be rolled out to Somali, Oromia, Amhara and SNNP—regions where vulnerability and humanitarian need, as well as the potential for national impact (particularly for the latter three regions, which account for 80 per cent of Ethiopia's population), is greatest. After refining the package of interventions and synthesizing learning and evidence from those three regions, the model can be adapted for other parts of the country where there are humanitarian-affected and/or vulnerable populations. This course of action can contribute to several SDGs, including SDG 10 on reducing inequalities.
 5. Redouble efforts to improve resource mobilization, budget allocation, budget use and expenditure tracking through the lens of public finance for children. In addition to increasing public spending on the social sectors, shift from off-budget to on-budget support, instituting measures that facilitate transparent tracking of spending, especially in relation to emerging priorities, such as ECD and adolescent development and participation. This course of action can contribute to several SDGs.
 6. Adopt a 'whole system' (multi-sectoral, multi-stakeholder, multi-level) approach to enhance protective factors that reduce vulnerabilities in out-of-school girls and boys. This focus is responsive to available evidence on the prominence of out-of-school girls' in-migration flows, as well as their risks of / exposure to a plethora of adverse outcomes and circumstances (e.g., trafficking, commercial sexual exploitation of children, teenage pregnancy, multi-dimensional poverty that is intergenerational). This 'whole system' approach should include addressing deep-seated social beliefs and norms that underpin different vulnerabilities in females compared to males, as well as coordination and joint programming between sectors or programme areas (e.g., child protection, health, education, social protection). To ensure that demand-side factors are sufficiently addressed, evidence-informed behaviour change interventions that engage all segments of society, including key decision makers and gatekeepers at household and community levels, will be an important component of the 'whole system' approach. This course of action can be regarded as a crosscutting approach that can contribute to several SDGs.
 7. To institutionalize gender mainstreaming across key sectors, establish costed operational plans for gender mainstreaming in sectors / line ministries (e.g., gender balance and gender-sensitivity in workforce development and management, including frontline service providers; expansion and maintenance of gender-sensitive infrastructure; violence prevention and response mechanisms; etc.). It is advisable for the government to work closely with private / business sector players and CSOs in this endeavour. MoWCY should be equipped with the mandate, resources and capacity to foster that joint action. This course of action can contribute to SDG 5 on gender equality.

8. In light of rapid urbanization, roll out integrated urban programming in small- and medium-sized towns, not just in large urban centres such as Addis Ababa and Dire Dawa. This programming should address the holistic prevention and response needs of children, adolescents and households in urban / peri-urban settings and should reflect and respond to social and behavioural factors that underpin identified shortfalls and inequities in urban settings. This course of action can contribute to SDG 11, which focuses on making cities and human settlements inclusive, resilient and sustainable.
9. Strengthen the availability and quality of administrative data on children, including adolescents, by: (a) developing legal and policy frameworks; and (b) formalizing institutional arrangements for harmonized data production, data sharing, interoperability and data access within and across sectors. The country's roll out of Civil Registration and Vital Statistics is an opportunity to validate information from administrative data systems. Integrating monitoring evidence from community-level and non-State actors should be pursued to paint a more complete picture of progress in key indicators, and to foster accountability for quality implementation of policies and programmes that produce meaningful results. This course of action can be regarded as foundational to several SDGs.
10. Implement a child- and adolescent-focused research agenda that addresses priority research questions (see Annex 2) for which answers are necessary to inform replication and scale-up decisions, as well as measure child- and adolescent well-being within the context of the SDGs. This course of action can be regarded as foundational to several SDGs.



ANNEX 1: Disparities in Selected Indicators



1. Poverty and Public Finance

Table 1.1. National, Urban and Rural Estimates of Selected Poverty and Public Finance Indicators

Indicator	National Estimate	Urban	Rural
Percentage of the population living below the national (monetary) poverty line	23.5	18.8	25.6
Multi-dimensional child poverty (MCP) rate (%)	88	42	94
Gross National Income per capita	US\$ 1,719	-	-
Human Development Index ranking (2017)	0.463		
(173 out of 189 countries)	-	-	-
Proportion of total government spending on essential services (education, health and social protection) (%)	35.6	-	-
Per capita government spending on education	US\$ 127.21	-	-
Per capita government spending on health	US\$ 13.38	-	-

Sources: For MCP rate: CSA and UNICEF Ethiopia (2018): Multi-dimensional Child Deprivation in Ethiopia. For proportion of government spending on essential services: MoF (2018), which includes spending for education and health. Data on social protection spending not available, and estimated based on the proposed budget assessed at 2.2%. Per capita government spending on education is calculated by dividing total government expenditure on education (MoF 2018) by total number of students enrolled in pre-primary, primary, secondary, TVET and higher education (MoE 2019). Per capita government spending on health is calculated by dividing total government expenditure on health (MoF 2018) by total projected population (CSA 2013). For all other indicators: United Nations Development Programme (UNDP). 2018. Human Development Indices and Indicators: 2018 Statistical Update.

2. Education

Table 2.1. Gender Disparities in Selected Education Indicators

Indicator	ESDP V Baseline (2007 E.C. [2013/14])	2010 E.C. (2017/18) ESTIMATES		
		National Estimate (Both sexes)	Females	Males
Gross Enrolment Rate (GER), pre-primary school (%)	33 (female) 35 (male)	44.2	43.1	45.1
GER, primary cycle 1 (Grades 1-4, including ABE) (%)	131 (female) 143 (male)	137.2	129.4	144.9
Net Enrolment Rate (NER), primary cycle 1 (Grades 1-4, including ABE) (%)	104 (female) 112 (male)	112.9	107.3	118.4
GER, primary cycle 2 (Grades 5-8) (%)	63 (female) 35 (male)	79.3	75.7	82.7
NER, primary cycle 2 (Grades 5-8) (%)	50 (female) 49 (male)	62.8	61.1	64.5
Completion rate: Grade 5 (%)	61 (male & female)	88	84.3	91.6
Completion rate: Grade 8 (%)	47 (male & female)	57.7	55.9	59.5
Grades 1-8 dropout rate* (%)	11 (male & female)	11.1	11.4	10.9
GER, Grades 9-10 (secondary) (%)	37 (female) 40 (male)	47.6	45.2	50.1
NER, Grades 9-10 (secondary) (%)	21 (female) 20 (male)	24	24.3	23.8
GER, Grades 11-12 (secondary)** (%)	–	13.1	11.8	14.3
NER, Grades 11-12 (secondary)** (%)	–	7.3	7.4	7
National Learning Assessment Grade 4*** (%)	40.1****	44.7*****	43.2	46.3
National Learning Assessment Grade 8*** (%)	35.3****	42.1*****	-	-

Data Source: Federal Ministry of Education. 2018. Education Statistics Abstract 2010 E.C. (2017/18).

GER = No. of students enrolled in a particular level of education (e.g., pre-primary, primary, secondary), regardless of age, expressed as a percentage of the official school-age population for that level

NER = No. of students enrolled in a particular level of education (e.g., pre-primary, primary, secondary) who are within the official school age for that level (pre-primary: 4-6 years old; primary: 7-14 years old; secondary: 15-18 years old)

NOTES: The GER can be greater than 100 per cent when there is a large number of overage (or underage) students, because it measures the number of students, regardless of age, as a percentage of the official school-aged population. The NER cannot exceed 100 per cent. When this is observed, values greater than 100 per cent can be attributed to the following reasons: (1) the reference date for entry to school does not coincide with the birth dates of all of the cohort eligible to enrol, (2) a significant portion of the population starts primary education earlier than the prescribed age and consequently finishes earlier, (3) there are inconsistencies in the enrolment and/or population data. (Source: <http://uis.unesco.org/en/glossary-term/net-enrolment-rate>)

*Dropout rate refers to learners who left formal schooling the previous year. Hence, the dropout rates noted in the table reflect dropouts in EFY 2009, not EFY 2010.

**After Grade 10, students can go to TVET colleges and Colleges for Teacher Education. Grade 11-12 GER and NER indicators do not include enrolment figures for those education paths.

*** Proportion of children scoring 50 per cent or higher in National Learning Assessment exams (passing grade, composite score)

**** Data from 2012

***** Data from 2016

In the following table, any cells shaded in red depict regions with the lowest/worst values for an indicator, and cells shaded in green depict the highest/best values.

Table 2.2. Regional Disparities in Selected Education Indicators

Indicator	KEY DIFFERENTIALS BY REGION:										
	Tigray	Afar	Amhara	Oromia	Somali	B-G	SNNP	Gambella	Harari	Addis Ababa	Dire Dawa
GPI, pre-primary	0.99	1.46	0.98	0.93	0.81	0.91	0.95	0.96	0.90	0.96	0.97
GER, pre-primary (%)	86.8	14.3	46.6	29.7	4.5	38.5	68.2	41	88.1	93.6	43.1
NER, pre-primary (%)	85.6	13	46.1	28.4	2.9	37.1	65.8	35.2	79.1	84.3	36.5
GPI, primary	0.94	0.90	0.95	0.87	0.80	0.86	0.90	0.93	0.84	1.15	0.91
GER, primary (%)	117.5	59.5	107.7	107.2	95.6	119.2	116.7	145.7	110.8	134.9	105.8
NER, primary (%)	110.9	50.9	96.1	99.7	82.9	99.2	109.8	108.9	98.4	105.9	91.6
GPI, secondary	0.99	0.75	1.08	0.78	0.72	0.77	0.78	0.70	0.88	1.11	0.83
GER, secondary (%)	46.3	11	36.1	25.3	15.2	36	30.4	58.6	36.2	85.3	33.1
NER, secondary (%)	35.8	4.4	16.8	12.2	6.4	13.5	17.9	14.3	17.8	54.5	15.5
Share of out-of-school children in primary-age population (%)	5	59.6	11.8	14.9	23.7	8.14	12.5	11.5	31.8	1.1	8.5

Data Source: Federal Ministry of Education. 2018. Education Statistics Abstract 2010 E.C. (2017/18)

GPI = Gender Parity Index, or the ratio of the number of female students enrolled at a given level (pre-primary, primary, secondary) to the number of male students at that same level; GPI = 1 indicates parity between the sexes; GPI from 0 to 1 usually indicates a disparity in favour of males; GPI greater than 1 indicates a disparity in favour of females.

GER = Number of students enrolled in a particular level of education (e.g., pre-primary, primary, secondary), regardless of age, expressed as a percentage of the official school-age population for that level.

NER = Number of students enrolled in a particular level of education (e.g., pre-primary, primary, secondary) who are within the official school age for that level (pre-primary: 4-6 years old; primary: 7-14 years old; secondary: 15-18 years old).

For the remaining tables in this annex, any cells shaded in red depict categories of children/women with the lowest/worst values for an indicator, and cells shaded in green depict categories of children/women with the highest values. Indicator data were obtained primarily from the 2019 Ethiopia Mini Demographic and Health Survey (EMDHS), which was the most-recent population-based data source available to explore disparities at the time the Situation Analysis was conducted.

3. Health

Table 3.1. Disparities in Selected Health Indicators derived from the 2019 EMDHS, According to Gender, Residence and Wealth Quintile

Indicator	NATIONAL ESTIMATE	KEY DIFFERENTIALS BY:								
		Gender		Residence		HH Wealth Quintile				
		Fem	Male	Urban	Rural	W1	W2	W3	W4	W5
Total fertility rate	4.6	--	--	2.3	5.2	6.4	5.6	4.9	4.3	2.6
Modern contraceptive use, currently married women (%)	40.5	--	--	47.7	37.7	27.2	33.9	43.7	43.6	51.1
Any ANC from a skilled provider (ANC 1) (%)	73.6	--	--	84.5	69.7	46.3	71.6	77.1	77.6	95.1
At least 4 ANC visits (ANC4+) (%)	43	--	--	58.7	37.4	20.6	35.9	41	46.9	69.7
Skilled delivery (%)	49.8	--	--	72.1	42.5	22	38.7	49.4	60.7	86.9
Percentage of women with a postnatal check during the first 2 days after birth (%)	33.8	--	--	47.6	28.8	13.3	19.7	29.9	43.2	62.5
All basic vaccinations among 12-23 mo. olds* (%)	43.1	43	43.3	57.3	36.9		34.6	39.9	44.3	64.7

*The following vaccinations count toward this indicator: 1 dose of BCG, 3 doses of DPT-Hep B-Hib, 3 doses of polio vaccine, 1 dose of measles vaccine

Data Sources: Total fertility rate: CSA and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF. Other indicators: EPHI and ICF. 2019. EMDHS 2019: Key Indicators. Rockville, Maryland, USA: EPHI and ICF.

NC: The EMDHS does not provide disaggregated estimates according to gender, place of residence and household wealth quintile.

Table 3.2. Regional Disparities in Selected Health Indicators Derived from the 2019 EMDHS

Indicator	KEY DIFFERENTIALS BY REGION:										
	Tigray	Afar	Amhara	Oromia	Somali	B-G	SNNP	Gambella	Harari	Addis Ababa	Dire Dawa
Total fertility rate	4.7	5.5	3.7	5.4	7.2	4.4	4.4	3.5	4.1	1.8	3.1
Modern contraceptive use, currently married (%)	36.3	12.7	49.5	38.9	3.4	36.7	44.6	33.2	30.3	47.6	30.3
Any ANC from a skilled provider (ANC 1) (%)	94	62.6	82.6	70.8	30.2	83.3	69.4	85.7	80.7	96.9	83.8
At least 4 ANC visits (ANC4+) (%)	63.9	31.1	50.8	40.6	11.1	55.9	34.1	31.8	38.8	81.8	61.7
Skilled delivery (%)	73.3	30.6	55.7	43.7	26	64.9	50.2	69.9	64.9	95.7	70.7
Percentage of women with a postnatal check during the first 2 days after birth (%)	62.9	23.1	39.8	26.1	10.3	45.3	32	54.8	45.2	73.5	48.5
All basic vaccinations among 12-23 mo. olds* (%)	73	19.8	62.1	29.9	18.2	66.7	38	38.3	45.8	83.3	53

The following vaccinations count toward this indicator: 1 dose of BCG, 3 doses of DPT-Hep B-Hib, 3 doses of polio vaccine, 1 dose of measles vaccine

Data Sources: Total fertility rate: CSA and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF. Other indicators: EPHI and ICF. 2019. EMDHS 2019: Key Indicators. Rockville, Maryland, USA: EPHI and ICF.

4. Nutrition

Table 4.1. Disparities in Selected Nutrition Indicators Derived from the 2019 EMDHS, According to Gender, Residence and Household Wealth Quintile

Indicator	NATIONAL ESTIMATE	KEY DIFFERENTIALS BY:								
		Gender		Residence		HH Wealth Quintile				
		Fem	Male	Urban	Rural	W1 lowest	W2 second	W3 middle	W4 fourth	W5 highest
Stunting prevalence (Height for age < -2SD) among under-fives	36.8	33.4	40.2	25.6	40.6	41.9	41.9	39.7	34.9	24.1
Wasting prevalence (Weight for height < -2SD) among under-fives	7.2	5.5	8.8	5.7	7.7	11.7	7.7	4.8	6.2	4
Underweight prevalence (Weight for age < -2SD) among under-fives	21.1	19	23	14.3	23.3	28	24.1	23.5	16	11.6
Overweight/obesity prevalence among under-fives (Weight for age > +2SD)	0.6	0.4	0.9	0.8	0.6	0.5	0.4	1.2	0.6	0.6
Vitamin A supplementation in past 6 mos. among 6-35 mo. olds	47.1	47.6	46.6	52.9	45	35.6	43.5	57.1	44	55.1
Iron supplementation during pregnancy for most-recent live birth	60	–	–	69.7	56.5	38.2	53.7	64.7	63.3	79.9
Low birth weight (<2.5 kg)	13.2	–	–	10.9	15.4	11.3	18.7	17.3	15.7	10.5
Anaemia in women	23.6	–	–	17	25.4	34.3	25.3	23.7	21	17.4
Exclusive breastfeeding rate, 0-5 mo. olds	58.8	NC	NC	NC	NC	NC	NC	NC	NC	NC

Data Sources: For low birth weight and women's anaemia indicators: CSA and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF. For all other indicators: EPHI and ICF. 2019. EMDHS 2019: Key Indicators. Rockville, Maryland, USA: EPHI and ICF.

NC: The 2019 EMDHS does not provide disaggregated estimates according to gender, place of residence and household wealth quintile for the indicator.

Table 4.2. Regional Disparities in Selected Nutrition Indicators Derived from the 2019 EMDHS

Indicator	KEY DIFFERENTIALS BY REGION (%):										
	Tigray	Afar	Amhara	Oromia	Somali	B-G	SNNP	Gambella	Harari	Addis Ababa	Dire Dawa
Stunting prevalence among under-fives	48.7	43	41.3	35.6	30.5	40.8	36.3	17.6	34.7	13.9	25.4
Wasting prevalence among under-fives	9.2	13.9	7.6	4.7	21.1	6.1	6.3	12.5	4.2	2.3	5.8
Underweight prevalence among under-fives	30.4	31.7	26.7	16.1	31.7	31.4	19.7	18.1	18.9	4.7	15.2
Overweight prevalence among under-fives	0.4	1.4	0.0	0.3	1.2	1.4	1.5	0.4	0.5	2.5	0.6
Vitamin A supplementation in past 6 mos. among 6-35 mo. olds	64.7	32.4	58.4	45.6	20.1	63.1	39.7	63.7	48.8	55.8	62.1
Iron supplementation during pregnancy for most-recent live birth	84.5	51.4	74.4	54.8	18.6	60.5	55.2	60.2	66.2	73.3	69.5
Low birth weight (<2.5 kg)	7.6	26.2	22.2	13.1	11.1	9.9	13.1	11.9	4.4	11.5	9.2
Anaemia in women	19.7	44.7	17.2	27.3	59.5	19.2	22.5	26.1	27.7	16	30.1
Exclusive breastfeeding rate, 0-5 mo. olds	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Data Sources: For low birth weight and women's anaemia indicators: CSA and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF. For all other indicators: EPHI and ICF. 2019. EMDHS 2019: Key Indicators. Rockville, Maryland, USA: EPHI and ICF.

NA: The 2019 EMDHS does not provide disaggregated regional estimates for this indicator.

5. WASH

Table 5.1. National, Urban and Rural Estimates of Selected WASH Indicators

Indicator	NATIONAL ESTIMATE	KEY DIFFERENTIALS BY:								
		Gender		Residence		HH Wealth Quintile				
		Fem	Male	Urban	Rural	W1 lowest	W2 second	W3 middle	W4 fourth	W5 highest
Percentage of the population with access to at least basic water services	41	NA	NA	80	31	NA	NA	NA	NA	NA
Percentage of men, women, girls and boys that have access to at least basic sanitation	7	NA	NA	20	4	NA	NA	NA	NA	NA
Percentage of the population with access to basic hygiene	8	NA	NA	23	4	NA	NA	NA	NA	NA

Data Sources: UNICEF and WHO. 2019. Progress on household drinking water, sanitation and hygiene 2000-2017. Special focus on inequalities.

NA: Not calculated; disaggregated estimates not available by household wealth quintile

6. Adolescents

The 2019 EMDHS did not yield indicator data specific to adolescents that allows for exploration of disparities. The following tables explore some disparities using available 2016 EDHS data. Education data of relevance to adolescents appear in the Education data tables (Tables 2.1 and 2.2).

Table 6.1. Disparities in Selected Indicators related to Adolescents, as derived from the 2016 EDHS, according to Gender, Residence and Household Wealth Quintile

Indicator	NATIONAL ESTIMATE	KEY DIFFERENTIALS BY:								
		Gender		Residence		HH Wealth Quintile				
		Fem	Male	Urban	Rural	W1	W2	W3	W4	W5
Age-specific fertility rate (per 1,000 live births) among females age 15-19 years	80	--	--	20	96	NA	NA	NA	NA	NA
Percentage of females age 15-24 who had sexual intercourse before age 15	9.4	9.4	--	3	11.4	NA	NA	NA	NA	NA
Percentage of males age 15-24 who had sexual intercourse before age 15	1	--	1	0.4	1.2	NA	NA	NA	NA	NA
Median age at first sex (in years) among females age 25-49 years	16.6	16.6	--	18.5	16.3	16.4	16	16.4	16.4	18
Median age at first sex (in years) among males age 25-59 years	21.2	--	21.2	21.5	21.1	20.9	21.7	21.2	20.9	21.3
Median age at first birth (in years) among females age 25-49 years	19.2	--	--	21.6	18.9	19	18.8	19	18.8	20.8
Percentage of women age 15-19 years who have begun childbearing (had a live birth or are pregnant with first child)	12.5	--	--	4.9	14.8	24	17.3	14.9	8.1	5.8
Percentage of 15-19 year olds who are thin (BMI < 18.5)	--	29	59	NA	NA	NA	NA	NA	NA	NA
Percentage of 15-19 year olds who are anaemic	--	19.9	18.2	NA	NA	NA	NA	NA	NA	NA
Percentage of 15-24 year olds with comprehensive knowledge about HIV	--	24.3	39.1	NA	NA	NA	NA	NA	NA	NA
Prevalence of FGM among girls age 0-14 years (%)	15.7	15.7	--	6.6	16.7	16.1	15.7	16	18.6	10.2

Data Source: CSA and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF.

NC: Not calculated because fewer than 50% of the males in that category began living with their spouse or partner for the first time before reaching the beginning of the age group

NA: Disaggregated estimates not available

Table 6.2. Regional Disparities in Selected Indicators related to Adolescents, 2016 EDHS

Indicator	KEY DIFFERENTIALS BY REGION (%):										
	Tigray	Afar	Amhara	Oromia	Somali	B-G	SNNP	Gambella	Harari	Addis Ababa	Dire Dawa
Median age at first sex (in years) among females age 25-49 years	16.1	16.2	15.5	16.7	17.9	16.5	17.8	16.2	17.7	20.4	17.7
Median age at first sex (in years) among males age 25-59 years	22.1	20.3	20.8	20.9	22.7	19	22.1	19.5	22.5	21.1	22
Median age at first birth (in years) among females age 25-49 years	19.2	18.6	18.8	18.8	20	18.4	19.5	19.2	20.4	NC	20.3
Percentage of women age 15-19 years who have begun childbearing (had a live birth or are pregnant with first child)	12	23.4	8.3	17	18.7	13.6	10.7	16.2	16.9	3	12.5
Prevalence of FGM among girls age 0-14 years (%)	11.3	77.8	34.8	7.6	25.7	19.1	11.6	3.4	6.7	1.8	9.6

Data Source: CSA and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF.

NC: Not calculated because fewer than 50% of women had a birth before reaching the beginning of the age group

7. Child Protection

Table 7.1. Disparities in Selected Indicators related to Child Protection, according to Gender, Residence and Household Wealth Quintile

Indicator	NATIONAL ESTIMATE	KEY DIFFERENTIALS BY:								
		Gender		Residence		HH Wealth Quintile				
		Fem	Male	Urban	Rural	W1	W2	W3	W4	W5
Birth registration rate among under-5 (%)	2.7	2.7	2.6	11.5	1.6	0.8	1.4	2.4	1.6	9.5
Percentage of women age 20-24 first married by age 15	14.1	NA	NA	NA	NA	NA	NA	NA	NA	NA
Percentage of women age 20-24 first married by age 18	40.3	NA	NA	NA	NA	NA	NA	NA	NA	NA
Median age at first marriage (in years) among females age 25-49 years	17.1	17.1	--	19.3	16.7	16.9	16.4	16.7	16.9	18.7
Percentage of children age 5-17 years engaged in child labour	24.2	18.9	29.1	9.4	27.5	NA	NA	NA	NA	NA
Percentage of women age 15-49 who have experienced sexual violence in the 12 months preceding the survey	6.5	6.5	--	2	7.7	9.5	9.4	8.3	5.7	1.8

NA: Disaggregated data not available

Data Sources: For indicator on child labour: CSA and International Labour Organization. 2018. 2015 Ethiopia National Child Labour Survey. Table 7.12. For all other indicators: CSA and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF.

Table 7.2. Regional Disparities in Selected Indicators related to Child Protection

Indicator	KEY DIFFERENTIALS BY REGION (%):										
	Tigray	Afar	Amhara	Oromia	Somali	B-G	SNNP	Gambella	Harari	Addis Ababa	Dire Dawa
Birth registration rate among under-fives (%)	2	1.6	1.3	2.1	1	1	3.4	2.5	5	24.2	18.5
Percentage of women age 20-24 first married by age 15	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Percentage of women age 20-24 first married by age 18	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Median age at first marriage (in years) among females age 25-49 years	17.2	16.4	16.2	17.4	18.1	17.1	18.2	17.3	18.5	NC(a)	18.7
Percentage of children age 5-17 years engaged in child labour	26.8	31.7	31.3	27.7	28.1	21.1	11.7	5.1	8.7	3.7	4.9
Percentage of women age 15-49 who have experienced sexual violence in the 12 months preceding the survey	6.2	1.4	6.9	9.4	0.3	4.6	3.7	7.3	2.6	1.4	3.5

Data Sources: For indicator on child labour: CSA and International Labour Organization. 2018. 2015 Ethiopia National Child Labour Survey. Table 7.12

For all other indicators: CSA and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF.

NA: Regional estimates not available





ANNEX 2: Priority Research Gaps

The 2019 Situation Analysis of Children and Women in Ethiopia examined progress in safeguarding the rights and improving the welfare of children and women in different realms. The analysis highlighted several evidence gaps, some of which can be filled through sound research.

This annex to the 2019 Situation Analysis National Report is organized according to the following themes or programme areas:

- Early Childhood Development (ECD)
- Education
- Health
- Nutrition
- WASH
- Child Protection
- Adolescents
- Social Protection

For each theme or programme area, there is a very short synopsis of the current body of evidence, followed by a list of priority research questions deemed salient to addressing shortfalls and inequities related to children and women.

These pages highlight content gaps, but the following are overarching gaps in the types of evidence needed to support scalable and sustainable strategies:

- Longitudinal data on dynamics, outcomes and their causal pathways among a cohort of children and adolescents over time (e.g., tracking the longitudinal impact of children exposed to various ECD interventions; outcomes in adulthood of adolescent girls (and in their offspring) who complete secondary school; the effect(s) of demographic phenomena such as urbanization on gender disparities, wealth disparities and regional disparities)
- Evaluation evidence with counterfactual data to ascertain the true 'impact' of intervention models or programmes
- Value-for-money analyses.

1. ECD

Overview	Priority Research Questions
<p>There is compelling global evidence that both extremely poor children and children affected by humanitarian crises—two large categories of children in Ethiopia—are often exposed to factors that can adversely affect their development. Evidence shows that when adversities in early childhood go unaddressed, they often have negative consequences in adulthood (e.g., reduced earning potential).</p> <p>Individual sectors (e.g., health, education, WASH, and to a lesser extent, child protection) are generating ECD-sensitive/ ECD-relevant data. However, there are ‘blind spots’ in the evidence base. Those blind spots largely relate to domains of ECD that are not addressed extensively by formal systems of care (e.g., in the health or education sectors). Because Ethiopia has never conducted a MICS, the status of Ethiopia’s children vis-à-vis critical ECD milestones related to literacy-numeracy and physical, social, emotional and cognitive development has not been systematically assessed.</p>	<ol style="list-style-type: none"> 1. How do children in Ethiopia fare on the standard ECD Index? Are there important differentials (e.g., urban-rural, pastoralist-agrarian, highland-lowland, disparities by wealth quintile) that should inform targeting and tailored programme implementation? 2. What are the key (a) missed opportunities and (b) implementation challenges in delivering quality ECD interventions at home / place of residence and in communities? 3. What common caring / parenting practices in Ethiopia (a) promote and (b) inhibit ECD? 4. What are the effects of humanitarian crises on ECD? Do those effects endure? 5. What is the minimum package of effective, scalable interventions that improve ECD outcomes in different sub-populations of poor and extremely poor children (e.g., urban poor, pastoralist children, very young children on the move)?

2. Education

Overview	Priority Research Questions
<p>The evidence base on education is fairly robust in Ethiopia and yields data on discrete aspects of education service delivery, coverage (e.g., school attendance and enrolment measures), quality and efficiency issues. Special research has also shed light on dynamics related to specific segments of children who are either included in or excluded from (e.g., out-of-school adolescents) the formal education system. The following are key sources of evidence:</p> <ul style="list-style-type: none"> • Administrative Data: <ul style="list-style-type: none"> › Education Management Information System (EMIS), as published in the FMoE Education Statistics Annual Abstracts › Refugee EMIS Abstract • Education Sector Budget Analyses/Briefs • Household or population-based surveys, such as the EDHS • Further analyses and qualitative research on dynamics and determinants related to various aspects of education. <p>There are data gaps related to the extent to which the formal the education system equips children to be productive members of society, as well as discrete issues such as violence in schools (see Child Protection).</p>	<ol style="list-style-type: none"> 1. What impact, if any, do alternative models of education service delivery (e.g., alternative basic education among pastoralists) have on educational attainment in adolescence? 2. What are the most effective, scalable and sustainable learning pathways to reach in-school and out-of-school adolescents? 3. To what extent do curricula and materials in the formal education system align with skills that are in demand in the labour market (i.e., skills for employability)? 4. What mechanisms and/or approaches best facilitate the school-to-work transition? 5. What is the theory of change by which social protection programmes, such as PSNP, impact education outcomes other than school enrolment (e.g., learning outcomes, grade repetition, transition from primary to secondary school)? 6. How do menstrual hygiene management interventions affect girls’ school attendance and school performance, if at all? What are the critical success factors in bringing about improvements related to these two issues? 7. How do girl-focused interventions in the education sector impact outcomes in boys? 8. How can language, cultural and other barriers be overcome to ensure that all children, including children on the move, access education?

3. Health

Overview	Priority Research Questions
<p>There is an extensive evidence base on health, with the country's HMIS (DHIS-2) yielding administrative data on issues such as service use.</p> <p>The EDHS, EMDHS and other population-based surveys (e.g., Malaria Indicator Survey) are important sources of evidence on the coverage of high-impact interventions, as well as on levels and differentials in knowledge, attitudes and practices. However, the 2019 Situation Analysis highlights a number of disparities that need to be verified and further explained through sound research.</p> <p>Quality of care is an important element in ensuring effective coverage of high-impact health interventions. Facility-based assessments, such as the Service Availability and Readiness Assessment (SARA) have shed light on various dimensions of service delivery functionality and readiness.</p> <p>In addition to the above, programme and strategy reviews (e.g., HSTP Mid-term Review, 2018), evaluations and special analyses employing mixed methods have yielded data on various dimensions of health-sector performance.</p>	<ol style="list-style-type: none"> 1. What are the drivers and determinants of higher mortality in boys compared to girls? 2. Why is the neonatal mortality rate not decreasing when major strides are being made in other forms of early mortality? 3. To what extent are the many quality improvement initiatives introduced under HSTP actually resulting in improved health outcomes in women and children? 4. How can the ability to replicate / scale promising health-sector innovations in Ethiopia (e.g., mobile clinics in pastoralist settings, family health teams in urban areas) be optimized to sustain progress and leave no one behind in both rural and urban areas? 5. To what extent, and through which causal pathways, can health service delivery under humanitarian conditions (e.g., mass vaccinations during disease outbreaks) address health-related shortfalls (e.g., related to child vaccination)? 6. What are the determinants of health care seeking in the private sector? Do those determinants vary depending on the type of service (e.g., delivery care, etc.)? 7. How can cooperation between government and non-State actors address unmet health needs (e.g., among adolescents) and further improve the quality of health care for all?

4. Nutrition

Overview	Priority Research Questions
<p>Nutrition is an aspect of children's and women's well-being that cuts across multiple sectors and stakeholders. As a complex issue that can be affected by certain factors (e.g., humanitarian events, WASH, disease frequency), and that can impact other factors and outcomes (e.g., child development and survival, school performance), there is both depth and breadth in the body of evidence on nutrition in Ethiopia. Below are major data sources:</p> <ul style="list-style-type: none">• Household / population-based surveys (e.g., EDHS, EMDHS)• Nutrition-specific surveys (e.g., Micronutrient Survey, Food Consumption Survey, SMART Surveys)• Administrative data (e.g., information systems such as DHIS-2, FEWSNET)• Special studies/analyses (e.g., peer-reviewed journal articles on nutrition interventions and drivers, Cost of Hunger Study)• Funding / spending analyses (e.g., FDRE's Tracking Funding for Nutrition in Ethiopia Across Sectors –Ethiopian Fiscal Years 2006 to 2008 (2013/14 to 2015/16))• Programme evaluations (e.g., on nutrition-specific and/or nutrition-sensitive effects of pilot programmes (e.g., Baby WASH and social protection programmes such as PSNP))	<ol style="list-style-type: none">1. How effective are women's nutrition interventions in improving the nutritional status of children and adolescents?2. What are the social determinants (e.g., behavioural, cultural, socio-political, economic) of infant and young child feeding and acceptable diets for children and women?3. Why do boys have worse nutritional status than girls?4. How is increasing urbanization changing dynamics, levels and trends related to over-nutrition, if at all?5. Are the nutrition-specific and nutrition-sensitive activities included in comprehensive integrated nutrition services effective in: (a) influencing sustainable behaviour change at household level, and (b) reducing chronic and/or acute malnutrition?6. What is the appropriateness and feasibility of innovative models and approaches (financing, programmatic) to improve diet diversity in Ethiopia?7. How did UNICEF with its partners impact the resilience capacity of the community? Is the real-time monitoring system supporting better resilience?8. How has the multi-sectoral approach for nutrition affected public financing for nutrition, and what are viable mechanisms to track resource allocation and efficiencies on nutrition / nutrition outcomes?9. Are social protection programmes to reduce poverty having any impact on: (a) the reduction of under-nutrition, and (b) improved diet diversity? If so, how?

5. WASH

Overview	Priority Research Questions
<p>The evidence base on WASH relates mostly to population and household access to improved drinking water sources, improved sanitation, and basic hygiene standards such as the presence of hand-washing facilities in households and the nature or extent of hand-washing with water and soap.</p> <p>Population-based assessments such as the EDHS, EMDHS, and Joint Monitoring Programme estimates yield population coverage data related to WASH.</p> <p>WASH-specific surveys such as the Ethiopia Socioeconomic Survey's Water Quality Test (ESS-WQT) also exist.</p> <p>Administrative data on all aspects of WASH—in both community and institutional settings—are limited.</p>	<ol style="list-style-type: none"> 1. Which is more cost-effective in improving child outcomes: 1) institutional WASH interventions in health facilities and schools; or 2) community WASH interventions? 2. What are the levers of change in shifting hygiene practices? 3. What effects do water stress and water scarcity have on WASH-related behaviours? Do those effects endure when those conditions do not exist? 4. How does climate-resilient WASH contribute to lowland resilience? 5. What is the scalability of climate-resilient WASH interventions in lowland areas? 6. To what extent do child deprivations in WASH explain high rates of malnutrition in children and women? 7. What are the most prominent constraints to improving hygiene practices for children during the first three years of life (e.g., via Baby WASH intervention models and programmes)?

6. Child Protection

Overview	Priority Research Questions
<p>Although survey data on specific issues (e.g., birth registration, FGM, child marriage, child labour) are available, there is no complete and up-to-date body of evidence on all dimensions of child protection. Gaps in routine or administrative data are particularly evident.</p>	<ol style="list-style-type: none">1. How can social protection efforts such as PSNP better contribute to the elimination of harmful practices such as child marriage?2. What are the most effective and sustainable strategies to reduce violence against children and women?3. What is the magnitude and nature of sexual exploitation, violence and abuse of boys?4. What are common coping and/or response mechanisms for boys and young men who experience sexual violence?5. What are the size estimates, vulnerabilities / capabilities, needs and outcomes of children on the move?6. What are the most-effective interventions to reach out to children on the move and ensure that their rights are respected?7. What are the size estimates, vulnerabilities, needs and outcomes of children left behind by migrating parents?8. What are the size estimates, vulnerabilities, capabilities, needs and outcomes of children with various disabilities / special needs?9. What impact, if any, do parenting and caring interventions have on the incidence and/or nature of violence against children, as well as on child migration?10. What are viable options for facilitating greater economic and/or civic participation of children on the move or humanitarian-affected children?11. What are the most effective interventions in the Ethiopian context to ensure justice for children?12. What links, if any, does exposure to violence have to other adverse protection outcomes (e.g., children in street situations, child marriage, contact with the law, etc.)?
<p>There is limited nationally representative data (e.g., via the EDHS) on specific dimensions of child protection, such as birth registration, FGM and violence against women and girls. However, those data sources have not enabled measurement of changes in social and gender norms (or the effectiveness of interventions aimed at addressing those norms) at the community level.</p>	
<p>Inter-agency and cluster assessments on violence experienced by IDPs / crisis-affected children and women provide further insight regarding the magnitude and nature of violence in humanitarian settings.</p>	
<p>Young Lives, a multi-country, longitudinal study of children and youth, in which Ethiopia is included, has shed light on various dimensions of child protection and child well-being. However, 'blind spots' exist with respect to highly vulnerable sub-populations of children, such as children with disabilities and children on the move.</p>	
<p>Technical research and assessments have been commissioned to address some of the above evidence gaps and inform programme interventions.</p>	

7. Adolescents

Overview

In Ethiopia, adolescents are a highly vulnerable sub-population.

The needs and dynamics underpinning adolescent development and participation must remain at the forefront of national dialogue, particularly given the potential for Ethiopia to reap a demographic dividend with increased investment in adolescents.

EDHS, child labour studies and population-based assessments have yielded estimates on discrete issues, such as adolescent fertility, nutrition, family planning use, child marriage, early childbearing, violence and labour participation. There is no cross-sectoral, multi-stakeholder platform to coordinate and harmonize efforts related to adolescents, or to synthesize and critically examine evidence on the various dimensions of adolescent development and participation.

However, Young Lives, a multi-country, longitudinal study of children and youth, in which Ethiopia is included, has shed light on selected outcomes in adolescents (e.g., violence, child marriage). It serves as the primary source of longitudinal data on children, including adolescents in the country. Briefs produced by GAGE presented highly salient evidence on issues affecting adolescents, such as the issues noted above.

Priority Research Questions

1. What is the quality of fit between current service models targeting adolescents in different sectors (e.g., health, protection, WASH) and priority needs of adolescents?
2. What is the nexus of adolescent sexuality, child marriage and exposure to violence, abuse and exploitation?
3. What are effective, scalable interventions to engage boys and men and change harmful social and gender norms and beliefs that contribute to adverse outcomes in adolescents, especially adolescent girls?
4. What are the most effective, gender- and adolescent-responsive social protection interventions in the Ethiopian context? What are the long-term impacts of those interventions, and the opportunities to maximize the impacts of those interventions for positive outcomes for adolescents?
5. What are effective and scalable intervention models to promote adolescent engagement and meaningful participation in the Ethiopian context (across development and humanitarian settings, and in pastoralist and agrarian populations)?
6. What services and/or programmes should constitute minimum packages of age-appropriate, gender-sensitive adolescent development and participation interventions for different age cohorts of adolescents (e.g., 10- to 14-year-olds, 15- to 19-year-olds) in Ethiopia?
7. What are the most effective services or interventions to strengthen adolescents' capabilities and empower and recognize them as key agents of change?

8. Social Protection

Overview	Priority Research Questions
<p>Ethiopia does not yet have a social protection MIS that yields administrative data on the country's various social protection programmes. However, EDHS rounds have produced estimates of population coverage of PSNP, as well as data used to estimate household wealth, the extent of multi-dimensional child poverty, and other salient background factors that shed light on the need for social protection. Other population-based data sources, such as household consumption and expenditure surveys, welfare monitoring surveys and vulnerability assessments also highlight the magnitude and nature of vulnerability and need.</p>	<ol style="list-style-type: none">1. What are the major determinants of sustainable graduation pathways for beneficiaries of safety net programmes (PSNP, UPSNP)? Are those determinants different for urban vs. rural households? For female-headed vs. non-female-headed households?2. What are the main determinants in increasing the fiscal space for child-sensitive social protection in Ethiopia?3. Do child-sensitive social protection efforts (including but not limited to PSNP and UPSNP) in Ethiopia impact girls and boys differently? Adolescents vs. younger children differently? If so, how?4. How can PSNP and other social protection programmes facilitate transformational shifts in harmful practices such as child marriage and FGM?5. Do PSNP and other social protection programmes impact migration dynamics and decisions? How?6. To what extent do economic interventions reduce the number and intensity of overlapping deprivations in children?7. How does the PSNP/USNP affect gender dynamics at the household level?8. What effect does social protection have on neonatal survival?9. How would a life-cycle approach change the current social protection landscape? Do we need categorical targeting?10. How will the Government of Ethiopia be in a position to sustainably maintain the current social protection flagship programmes, and what would a long-term financing strategy and investment case for social protection look like?11. To what extent do PSNP/USNP contribute to reduced stigma and discrimination faced by marginalized groups?
<p>Special studies and evaluations, such as those listed below, have also produced evidence that should inform programme design and scale-up decisions:</p> <ul style="list-style-type: none">• Budget briefs/public finance analyses• Poverty analysis studies (e.g., World Bank Poverty Assessments for 2014, 2015)	
<p>Programme evaluation evidence (e.g., preliminary findings on impact evaluation of PSNP) and pilot research (e.g., IN-SCT, UPSNP, CBHI) also exist.</p>	

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Ministry of Finance

Ministry of Finance
P.O.Box: 1037 Or 1905, Addis Ababa, Ethiopia
Email: infopr@mofed.gov.et
Telephone: +251 11 155 2015
Fax: +251 11 155 5189
Website: www.mofed.gov.et

unicef 
for every child

The United Nations Children's Fund
P.O.Box 1169, Addis Ababa, Ethiopia
Email: ethcommunication@unicef.org
Telephone: +251 11 518 4000
Fax: +251 11 551 1628
Website: www.unicef.org/ethiopia